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RECOVERY FROM DRUG DEPENDENCE: EXPERIENCES OF SERVICE USERS IN A CHRISTIAN FAITH-BASED AGENCY

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Declaration

I declare that this thesis is my original work. It has not been submitted in part or whole for any other degree or professional qualification.

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Comfort Jinadu

April 2012

Dedication

I dedicate this thesis to the Almighty God and everyone that has added value to my life and PhD experience. Especially: my loving parents late Frederick Tipping and Elizabeth Tipping; my sponsors Buki Jinadu, Emmanuel and Henry Tipping; University of Edinburgh; The Sym Charitable Trust and Roger and Sarah Bancroft Clark Charitable Trusts; Redeemed Christian Church of God Apapa Family, my supervisors Professor Vivienne Cree and Dr Afe Adogame; my external and internal examiners, Dr Gillian and Dr Robertson, respectively; my lecturers, especially Professor Jan Webb; my children, the Tipping and Jinadu families; Wellspring Rehabilitation Centre, Lagos, Redeemed Christian Church of God, Faith City and The Redeemed Christian Bible College families, my friends, pastors and research informants.

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Abstract

Research in the field of drug dependence and recovery emphasises the need for more understanding of the concept of recovery from dependent drug use. This study explored the ways in which dependent drug users recover from drug dependency in a Christian faith-based agency in Lagos, Nigeria. The strategy employed was a qualitative research design using a case study approach. Instruments for data collection were qualitative interviews and observation methods; agency records were also accessed for background information purposes. Three stages of the recovery process were explored: motivation for recovery, disengagement from drugs and maintenance of recovery. In each of these stages, psychological, socio-environmental and spiritual elements were identified as significant factors in the recovery process. The offer of treatment from a Christian faith-based agency seemed to be the most important factor in motivating informants to engage in treatment in the first place. At the disengagement stage, psychological and socio-environmental issues came to the fore, with a personal commitment to change and support from significant others including peers becoming important. Spiritual factors played a significant part at this time, however, including teaching and Bible reviews and prayers. Maintenance of recovery was found to be facilitated by psychological strategies such as positive self-talk and avoidance of triggers of drug dependency; by socio-environmental factors including supportive relationships; and by spiritual elements, which centred on the adoption of a Christian lifestyle. The findings conclude that although recovery from drug dependence is achieved through various routes, the most significant factor for the informants in this study was the spiritual intervention received.

Chapter 1 - Introduction

1.1 Background

Dependence on a psychoactive substance is characterised by persistent drug seeking behaviour (United Nations International Drug Control Programme 1997; 2006) which often leads to a cycle of treatment, recovery and relapse, frequently occurring for many decades (Scott, Foss et al. 2005). Because of this, drug dependence has been viewed as a chronic relapsing disorder (Morse and Flavin 1992; World Health Organization 2008), hence the popular adage, 'once an addict, always an addict'(Biernacki 1986). However, evidence from research and self-help literature suggests that drug-dependent persons can, and do recover from drug dependency (Biernacki 1986; Prins 1995; McIntosh and McKeganey 2000; Alcoholics Anonymous 2007; Laudet 2007). The implications for research and practice highlight the need for a better understanding of the concept and process of recovery (Biernacki 1986; Prins 1995) Recent studies by the Betty Ford Institute (2007), Laudet (2007) and White (2007) also stress that the concept of recovery is not well understood and needs more investigation.

Responses to alcohol and drug problems differ considerably around the world (World Health Organization 1993) and so it is necessary to explore the recovery process within particular contexts. Building on this awareness, this study attempts to contribute to the understanding of recovery from dependent drug use by exploring the experiences of service users in Wellspring Rehabilitation Centre, a Pentecostal Christian faith-based treatment agency in Lagos, Nigeria. In addition, existing

theoretical ideas of recovery will be explored in the study context, to locate the different elements within recovery.

A qualitative design has been used for the study to enable an in-depth exploration of the process of recovery. It is hoped that the study will achieve the following:

1. It will add to existing knowledge on the concept of recovery, particularly in the study area where there is little research evidence on drug dependence and recovery;

2. It will provide insights that will be useful for research and practice;

3. It will improve services of the agency being studied.

1.2 Motivation for the study

Inspiration for the study came from the need to provide better care for drug-dependent persons, in particular, persons who find it difficult to resolve drug dependence, from my experience of caring for those with drug dependence problems in a Christian treatment agency, in Lagos, Nigeria. I was keenly interested to find out how some people achieve recovery from drug dependency, and, at the same time, why others do not; they either fail to complete treatment or resume consumption after a period of abstinence. Moreover, as a practitioner, I wanted to be able to assist those who seek help with resolving drug dependency and as a member of the management staff of the agency, contribute towards improving the services of the agency that I

work for. In addition, I identified that gaps in the literature point to the need for more understanding of the processes of recovery and I was challenged to carry out research that will make a contribution in this regard.

1.3 Purpose of study

The aims of this study are two-fold: first, to gain more understanding about recovery from drug dependence; second, to locate routes for recovery.

1.4 Research questions

The main question guiding the study is, 'how do dependent drug persons recover from drug dependence in Wellspring Rehabilitation Centre, a Christian faith-based agency in Lagos, Nigeria?' Other research questions also explored are as follows:

- What are the conditions associated with dependent drug use?
- What are the roles of the family, peers and the agency in facilitating recovery from dependent drug use?
- What are the routes to recovery?

1.5 Theoretical underpinnings

Different perspectives on drug dependence, treatment and recovery have existed side-by-side and in competition with each other, hence, there are different treatment approaches and ways of thinking about recovery: medical, psychological, socio-environmental and spiritual. The literature review will explore each perspective in more detail, looking first at understandings of drug dependence, treatment and recovery. Before going on to the literature review, it is necessary to explore the terminology which will be used throughout the thesis.

1.6 Concepts

This section explores the concepts used in the study for two reasons: first, to provide clarity about the terms being discussed since a concept may mean different things to different people; second, to define the way in which concepts will be used in this study.

Drug

The United Nations International Drug Control Programme operates as the regulatory body for drug control all over the world, collecting data and setting standards. It defines the term ‘drug’ as any substance that when ingested modifies perception, mood or consciousness. (United Nations International Drug Control Programme 1997) Psychoactive drugs are classified into three as follows:

1. The nervous system depressants: These are opium, morphine, heroin, codeine, sedatives (Barbiturates and tranquilizers), solvents and alcohol.

2. The nervous system stimulants: These include cocaine, synthetic stimulants like amphetamines and ecstasy, kola-nuts, nicotine, and caffeine.

3. Hallucinogens: Hallucinogens include lysergic acid diethylamide (LSD) and cannabis (marijuana or hashish).

In this study, all substances defined as psychoactive drugs described above will be defined as drugs. In the study context drugs have their local names. Cocaine is called 'coco, coke, rock (or oko as they refer to it in Yoruba language), crack, and Charlie'. Heroin is called 'gbana', white or brown Italian according to country of origin and brown sugar. Cannabis is called by several names such as 'igbo' in the local language and by other popularly known names such as Indian hemp, weed, and marijuana. (A comprehensive list of drugs and their common names is provided in appendix 1.)

Drug use

The term 'drug use' in the literature refers to the ways people use drugs such as occasional and regular use of drugs. It is commonly accepted that occasional use may not cause physical or psychological harm; in contrast, regular drug use is widely thought to have harmful effects (United Nations International Drug Control Programme 1997).

Drug misuse and abuse

'Drug misuse' is usually defined as the excessive or inappropriate use of licit and illicit substances in such a way that it may result to harm to an individual. 'Drug abuse' can be used as a stronger term, describing a pattern of psychoactive substance use that causes damage to mental or physical health of the user (United Nations International Drug Control Programme 1997). However, there is considerable slippage between the terms, which are often used inter-changeably in the research and practice literature.

Dependence and addiction

The terms 'drug dependence' and 'drug addiction' are also used to mean the same thing. The term 'addiction' came into use in the late 20th century in medical terminology, and was defined as:

> 'a condition brought about by the repeated administration of any drug such that the continued use of the drug is necessary to maintain normal physiological function, and discontinuance of the drug results in definite mental and physical symptoms.' (Segal 1988 : 50).

However, the WHO Expert Committee on Drug Dependence in 1963 adopted the term 'dependence' in favour of addiction. More recently, it has defined drug dependence as:

> 'A cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of psychoactive drug (or drugs) takes

> on a high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behaviour. Determinants and problematic consequences of drug dependence may be biological, psychological or social, and usually interact.' (United Nations International Drug Control Programme 1997: 11).

The American Psychiatric Association (2000) suggests that the marker for drug dependence in its revised Diagnostic and Statistical Manual of Mental Disorders is: 'A maladaptive pattern of drug abuse, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12 month period:

1. Tolerance, as defined by either of the following:

a. need for markedly increased amounts of the substance to achieve intoxication or desired effect

b. markedly diminished effect with continued use of the same amount of substance

2. Withdrawal as manifested by either of the following:

a. the characteristic withdrawal syndrome for the same substance (refer to Criteria A and B of the Criteria sets for Withdrawal from specific substances)

b. the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recovery from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption.' (American Psychiatric Association 2000: 197).

It is this definition of drug dependence which I have chosen to use in this study. It is a comprehensive definition and clearly defines the elements of drug dependence. In addition, it is widely accepted in the expert literature on the topic.

Recovery from drug dependence

Just as there is no agreement over what constitutes dependence, there is no consensus definition of the concept of 'recovery' (White 2007). The American Society of Addiction Medicine in 2001 defined recovery as: 'overcoming both the physical and psychological dependence to psychoactive drug while making a commitment to sobriety.' (Laudet 2007: 245).

This definition is limited because it defines recovery only in terms of substance use. Research evidence shows that recovery from drug dependence is much more than abstinence from dependent drug use. For example, the study by Laudet (2007) suggests that recovery is an opportunity to live a new and better life, and a process of self-improvement. The Betty Ford Institute (2007) offers a working definition of recovery, bringing together a panel made up of researchers, treatment providers, recovery advocates and policy makers. This group refers to recovery from drug dependence as: 'a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.' (Betty Ford Institute 2007: 222).

There are a number of key ideas here. The word 'voluntary' reminds us that one of the key elements of recovery is the 'willing and voluntary pursuit of the behaviours which make up recovery'. In addition, a 'maintained lifestyle' alludes to recovery as a process and a sustained status. Further, 'sobriety' points to abstinence from alcohol and all other non-prescribed drugs (tobacco was not included here however).

Sobriety is said to be a primary and necessary criterion for a recovery lifestyle. It is classified into three: ‘early sobriety’ (1–11 months); ‘sustained sobriety’ (1–5 years); ‘stable sobriety’ (5 years or more). Personal health is referred to as improved quality of personal life, defined and measured by validated instruments of the WHO quality of life (QOL) instruments such as physical health, psychological health, independence, and spirituality. In addition, citizenship is defined as living with regard and respect for others. However, the Betty Ford Consensus Panel (2007) cautioned that their definition should not be viewed as a final answer, but one which may lay the foundation for future definitions of recovery. Further, the panel called for more research to establish the clinical importance of the parameters of recovery. They identified the need to address the following issues:

1. To determine if those who have ‘stable sobriety’ have a better chance of remaining in recovery than those who have ‘sustained sobriety’ over a period of one year.

2. To determine the appropriate threshold of sobriety, such as one, three and five or more years.

3. To determine if abstinence can be less sustained by those who have achieved abstinence and are still smoking than those who have quit smoking.

4. To establish the role of personal health and citizenship in sustaining sobriety.

White (2007) also offers a definition of recovery. He argues that: ‘Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.’ (White 2007: 236). This implies that as a process, recovery occurs over time and recovery initiation is different from recovery maintenance. Depicting recovery as a sustained status means that recovery can alter a person’s identity and suggests that recovery implies external validation such as the individual reaching a point of durability. proposes three temporal categories of recovery, in common with the Betty Ford Consensus Panel of the same year. These are as follows: ‘early recovery’ (less than 1 year); ‘continuing recovery’ (1-5 years); and ‘long-term recovery’ (more than 5 years) (White 2007: 236-239)). He draws attention to the role of individuals, families and communities in taking responsibility for managing their own recovery process over time and becoming experts on the recovery processes. Further, he argues that the application of recovery is limited to those who have severe alcohol and other drug (AOD) problems such as recommended by DSM-IV criteria for abuse or dependence. Significantly for this study, he acknowledges the existence of spiritual as well as secular frameworks for recovery. He also accepts the importance of free will and individual choice in the ways that people manage their alcohol and drug problems. He believes that instead of focusing on a particular method of resolution (for example, abstinence or harm reduction), individuals should be able to choose their own paths for recovery. They should be able to develop healthy,

productive and meaningful lives, reflected by internal changes (such as new knowledge, values, thinking patterns, attitudes, personal identity, decisions, skills, behaviours, and character traits) and external changes (such as rituals of daily living and important changes in interpersonal relationships particularly with family and friends and changed relationship with community measured by citizenship and service). The idea of healthy, productive and meaningful lives also suggests improvements in the physical quality of life, such as physical and emotional health, and improvements in a person's intimate, family and social relationships. At the same time, the anti-social behaviours associated with the lifestyle of AOD should be replaced by behaviours that contribute to the society. This broad approach to recovery will be extremely useful for this study.

Governmental bodies have also provided definitions of recovery. For example, The U.K. Drug Policy Commission Recovery Consensus Group 2008 defines recovery from problematic substance use as: 'Voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'(2008: 8). More recently, there is further shift in emphasis for drug treatment from control over substances in favour of recovery. For example, the 2010 U.K. drug strategy views recovery as: 'consisting of three overarching principles: freedom from drug dependence, well-being and citizenship.' (HM Government UK 2010: 18). This report also suggests that recovery is an individual and a person-centred journey that that will mean different things to different people.

Reviewing the definitions across the board, various aspects will be picked up in this study and will be interrogated further in the analysis.

Relapse

In the field of drug dependence and recovery, 'relapse' alludes to the resumption of drug-seeking and drug-taking behaviour after a period of abstinence (See, Fuchs et al. 2003). This concept has also been defined as both an event and a process; Perfas (2006) suggests that it is an event of resumption of drug-taking behavior after a period of abstinence, and a process whereby signs to recommence use begin to manifest themselves before actual resumption of use. Relapse in this study is referred to as the resumption of drug-taking behavior after a period of abstinence.

Service users

The term 'service users' is commonly used today to describe people who utilise services in health and social care settings, in preference to terms such as 'patient' or 'client' which are felt to be judgmental and paternalistic (Heffernan 2006; McLaughlin 2009; McLaughlin 2010). In this study, research informants who were either in treatment at the time of the study, had completed or accessed treatment, are referred to as service users.

1.7 The study context

In order to locate the study in its context, social backgrounds including demographic characteristics, ethnicity, religion and drug situation will now be discussed.

Demography

The publication of the Nigerian Population Commission (NPC) (2009) provides the most recent information on the population characteristics in Nigeria. This suggests that there are 140,431,790 people from head-counts of persons in Nigeria, a little over half of whom are within the age group, 0-19 years. This means that the population is largely young. Data from the 2006 study suggests that 92% of children and young people lived at home with their parents. It also states, interestingly, that those who lived with their parents, stayed on at school, and were involved in religious activities were less likely to smoke, drink or take drugs. The study suggests that this is due to closeness to their parents, responsiveness to parental attitudes and the nurture provided in a family environment. However, the study also revealed that one in five children were in the labour force, and one-third of the youths (aged 18-24) were in employment such as agriculture, manufacturing professional and technical occupation, with non-literate youths mostly in agriculture and some working as unpaid family workers. This suggests that they were exposed to other environments quite early in life, spending many hours away from home, and therefore at greater risk from adverse influences.

Ethnicity

The Nigerian Tourist development Corporation (2008) reveals the ethnic diversity in Nigeria; about 374 ethnic groups. It further suggests that there are three major ethnic groups which constitute about 40% of the population: the Hausa people in the North, the Yoruba people in the West and the Igbo people in the South (2008). The report also indicates that there are other significant groups; the Tiv's, Kanuri, Nupe, Gwari, Igala, Jukun Idoma and Fulani in the North, Edo, Urhobo in the South west, Ijaws in the south, and Ibibio in the South east (figure 1.1). Lagos, which is the study context, is a commercial centre and the former capital of Nigeria. Lagos city is located in Lagos State, in the western part of Nigeria.

There are three main indigenous languages in Nigeria. These are Hausa, Yoruba and Igbo. However, English is the official language. In the study context, Lagos, the major language spoken is Yoruba. However, people from other ethnic groups live in Lagos, and this is reflected in the bio-data of informants although a majority of the informants were Yoruba. This explains why one local language was used in the interviews in addition to English language and Pidgin English.

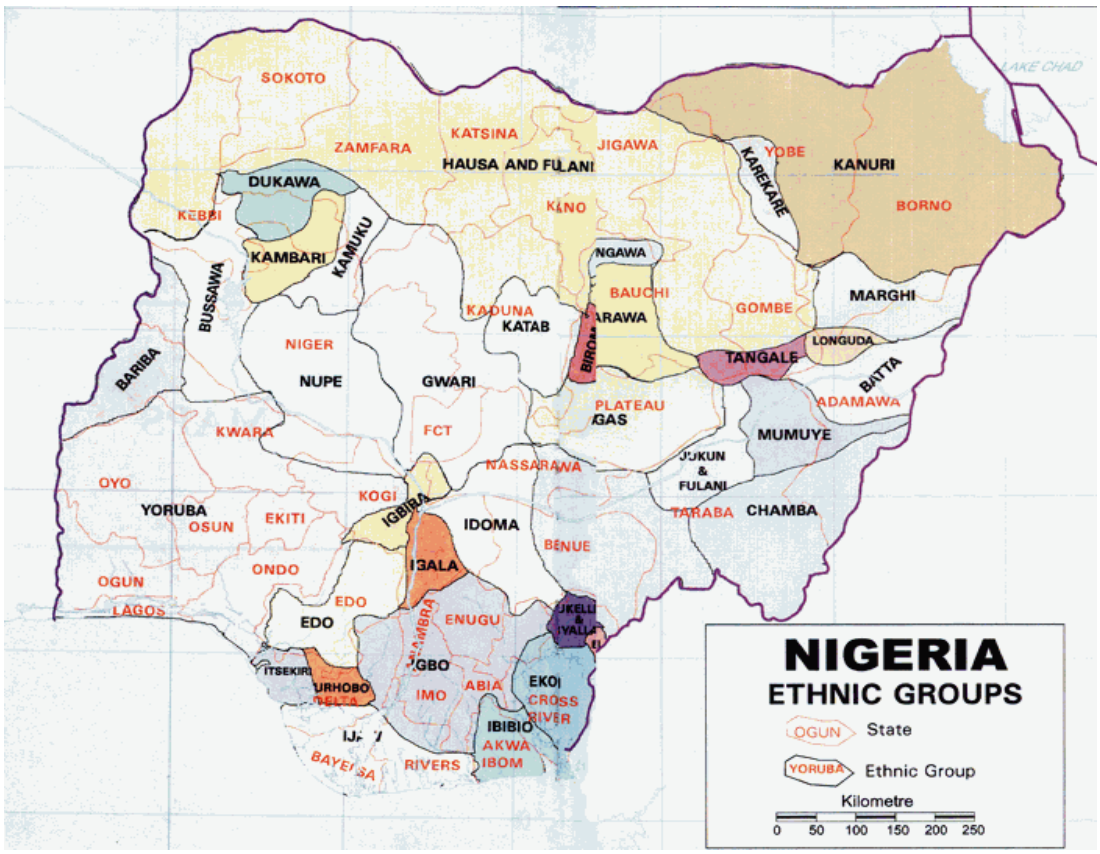

Figure 1.1- Ethnic map of Nigeria

(Source-www.onlinenigeria.com/mapethnic.asp#)

Religion

There are three main religious affiliations: Islam, Christianity and African traditional religion. Islam is mainly practised in the northern and some parts of western Nigeria. Christianity and African traditional religion are practiced in the south and western parts of Nigeria. Further discussion on the belief systems and implication for recovery are presented in chapter 2.

1.8 Drug situation in Nigeria

The discussion in this section will focus on common drugs and patterns of use and impact of drugs on users on society

Common drugs and pattern of use

There are many types of drugs consumed in Nigeria. The United Nations Office on Drugs and Crime (UNODC) (2010) suggests that the main drugs consumed in Nigeria are cannabis, sedatives, stimulants, heroin, and cocaine. Other drugs of abuse reported in other studies are volatile substances, cigarettes and alcohol. Current pattern of use for these drugs is presented in figure 1, and described below:

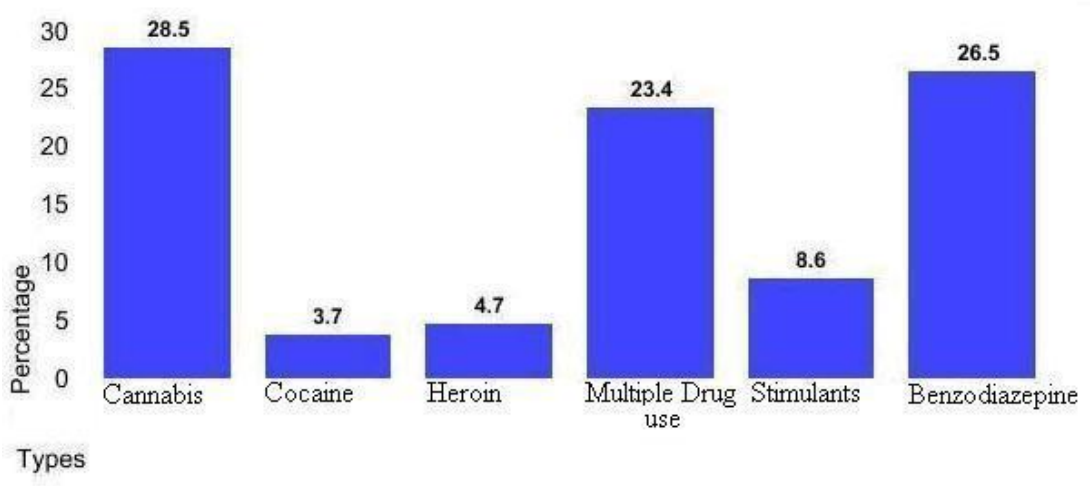

Figure 1.2 - Current drug use pattern in Nigeria (source- UNODC, Nigeria, 2010)

Cannabis is locally known as Indian hemp or hemp, igbo, stone, grass, hashish, grass, wee wee and marijuana (Odejide 1993). Previous studies suggest that cannabis is the

most abused psychoactive substance in Nigeria (National Drug Law Enforcement Agency 1997; United Nations Drug Control Programme 1998; United Nations Office on Drugs and Crime Nigeria 2010). UNODC (2010) also claims that cannabis is cultivated in Nigeria, mainly for domestic consumption.

Sedatives are also popular drugs of abuse. These are drugs administered to calm a patient down, therefore easing agitation and permitting sleep (MedicineNet.com 2011). The popular types of sedatives in Nigeria are benzodiazepines and barbiturates. Current pattern of benzodiazepines abuse, was estimated at 26.5% by UNODC (2010), coming next to cannabis abuse.

Another prevalent drug of abuse is amphetamine. This drug is a stimulant and known to decrease fatigue, increase the pain threshold, improve physical and verbal performances, and increased sense of well-being (Odejide 1993). UNDCP (United Nations Drug Control Programme 1998) suggests that amphetamine was used as an energizer by casual labourers, farmers, soldiers and long distance drivers to enable them work for long hours, and its use cuts across all age groups including elderly workers (1998). Odejide (1993) claimed that the substance is sometimes called pep or super-man pills. Amphetamine is one of the commonly abused drugs in Nigeria (United Nations Drug Control Programme 1998). UNODC (2010) report puts percentage of stimulant use as 8.6%, of psychoactive drug used.

In comparison, heroin and cocaine are drugs that are not majorly abused. UNDCP (1998) rapid assessment studies of four geo- political zones in Nigeria: Lagos, Ilorin, Port- Harcourt and Kaduna revealed that heroin and cocaine were reported mostly for Lagos and other cosmopolitan cities like Ibadan, Port Harcourt and Kano. This implies that in Nigeria, the abuse of hard drugs is an urban problem and effective programmes of drug prevention can limit the spread beyond urban areas. UNDCP (1998) in addition identified that abuse of heroin and cocaine is common to both the rich and the poor, the unemployed and street beggars and mostly associated with the 19-25 age group. Recent data shows that consumption of heroin and cocaine relative to other drugs is 4.7% and 3.7% respectively (United Nations Office on Drugs and Crime Nigeria 2010).

Furthermore, volatile substances are abused in Nigeria. Volatile substances are often referred to as inhalants, are a diverse group of psychoactive substances that are defined by their mode of administration (European Monitoring Centre for Drugs and Drug Addiction). These substances include deodorants, glue, lighter refills, air fresheners and alkyl nitrates. UNDCP (1998) reported that adhesives and glues are used by labourers and street children in Nigeria. The report also suggests that the first use of volatile substances is between ages 12-18 years, followed by 19-25 years.

Regarding alcohol consumption, UNDCP Nigeria (United Nations International Drug Control Programme Nigeria 1999) of Rapid Assessment of Communities in Lagos showed that alcohol was the most used licit substances in most communities in

Lagos, with the exception of Shitta community in Surulere, where illicit drugs such as cannabis is more commonly used. The report also indicated that cigarettes and tobacco came next to alcohol in terms of prevalence of drug use. The UNODC study suggests that multi-drug use is popular, and accounts for 23.4% of the country's drug use pattern, coming next to sedatives.

Impact of drugs on Nigerian users and society

Drug abuse and dependence affect both the individuals and society as a whole. Cannabis use in Nigeria has been found to be associated with severe psychopathologies (Adelekan 2000; Oshodi, Ikeji et al. 2009). Furthermore, studies have identified problematic effects of stimulants like cocaine, amphetamines and lysergic acid diethylamide (LSD), including sleeping disorders, poor appetite, restlessness, irritability, suicidal depressions, ecstatic paranoia, hallucinations, panic reactions, sensory disorientations and sometimes death (United Nations International Drug Control Programme 1992; National Drug Law Enforcement Agency 1997). Meanwhile, heroin has been found to cause dependence, blood-borne viruses and psychological disorders (Teeson 2002). At the societal level, it is widely known that crimes such as robberies and assault are related to drug abuse (United Nations Drug Control Programme 1998). Other effects on society are the incidence of HIV/AIDS (Acquired Immune Deficiency Syndrome); the UNODC (2010) suggests that in a significant number of cases, transmission has been through injecting of drugs.

1.9 Treatment of drug-dependent persons in Nigeria

The United Nations Office on Drugs and Crime (UNODC) Nigeria (2004) reported that there were 72 treatment and rehabilitation facilities in Nigeria. These facilities included government-owned specialised units for the treatment and rehabilitation of drug-dependent persons in psychiatric and general hospitals, non-governmental organisations and traditional healing centres.

The first specialised centre for the treatment of drug-dependent persons was the Neuropsychiatric hospital, Aro, Abeokuta, established in 1983. Other federal government-owned psychiatric hospitals are the Psychiatric Hospital, Yaba, Lagos, Psychiatric Hospital, Uselu, Benin City, Federal Psychiatric Hospital, Calabar, Federal Neuropsychiatric Hospital, Kaduna and Psychiatric units in teaching hospitals. Other facilities in this category include state-owned and non-governmental agencies like Mmaku Rehabilitation Centre, Enugu. Islamic healing centres known as the Makaranters exist in the Northern parts of the country such as Kano. Some Christian faith-based treatment agencies in Lagos are: the W.R.C Ojodu; Christ Against Drug Abuse, Ikeja; House of Joy, Surulere; and New Life Drug Addicts Rehabilitation Centre, Lekki.

In reviewing service-provision in Nigeria, Adelekan and Morakinyo (2000) identify five different approaches for the treatment of drug-dependent persons. These are:

1. Western-oriented medical treatment: The practice involves drug-assisted detoxification and pharmacological treatment of complications of drug dependence in Western-orthodox facilities. This treatment is followed by psychological treatment, vocational rehabilitation and after-care services. This is the approach used by government agencies and in private services.

2. Combination of Western medical with Christian religious approach: This approach offers a combination of Western drug treatment and Christian practices.

3. A largely religious-oriented approach, which might be either Christian or Islamic: An exclusively Christian approach offers Christian practices and pastoral care; Islamic healing centres offer intensive prayers, and drinking of water washed out from Qu'ranic writings. Adelekan and Morakinyo (2000) indicate that more drug users use religious facilities in Nigeria than any other form of service.

4. Traditional methods of treatment: These are based on indigenous cultural traditions. Traditional diagnosis of problems is by spiritual consultation, and treatment may involve sacrifices and ingestion of herbal and other preparations. Traditional healing methods have been in existence long before the introduction of Western orthodox methods, and exist in different parts of the country. Traditional

healers are known as ‘Babalawos’ and ‘Onisegun’ in the Western region and ‘Dibias’ in the Eastern region.

5. 12 steps Minnesota approach: The Minnesota Model of treatment is patterned after the Alcoholic Anonymous (A.A.) model of treatment. Adelekan and Morakinyo (2000) note that the model is practised in modified forms in the non-governmental organisation, such as ‘But for His Grace’, located in Ibadan in Western Nigeria.

In examining the treatment approaches used by different agencies, Adelekan and Morakinyo (2000) note that in most facilities, clients were usually referred by their relatives, or directly recruited from the streets by some Christian agencies. The Western-oriented agencies also received referrals from the criminal justice system and law enforcement agencies. The profiles of clients from all treatment and rehabilitation facilities were as follows:

- Most of the clients were aged between 15-40 years, and most were males.
- Clients came from all socio-economic strata.
- Most clients had acquired a level of educational attainment, but the majority had dropped off from the secondary school or tertiary institution.
- Cannabis was the most commonly-abused substance; alcohol, the next. Other substances used were heroin and cocaine.

- Cannabis was usually smoked or eaten. Cocaine and heroin were either sniffed or smoked. Drug injection was not found to be a popular method of ingestion among clients.

Adelekan and Morakinyo (2000) report that the various treatment agencies had no means of measuring the effectiveness of their services, although there were claims of perceived effectiveness based on the following measures: abstinence, occupational rehabilitation, social re-integration, rate of relapse and increased religious activities. Estimates of the success rate ranged from 30-60% by the Western-oriented medical services to 100% by the other approaches.

1.10 The study institution

This study will be located in Wellspring Rehabilitation Centre, a Christian faith-based residential centre with programme of treatment from drug dependency. It is a registered non-governmental organisation (NGO) established in 2003 in Nigeria. The agency is also an arm of the welfare ministry of the Redeemed Christian Church of God, Apapa family. (The 'family' is an umbrella term for a collection of parishes within the Redeemed Christian Church of God.) The agency is devoted to meeting the spiritual, recovery, vocational and resettlement needs of dependent drug using individuals, in particular, those living on the streets, popularly known as 'area boys'.

Treatment programmes

The Wellspring Rehabilitation Centre provides a system of care which incorporates Pentecostal Christian faith based model of drug treatment of drug dependency, vocational training, social re-integration and aftercare. The Wellspring's Centre's programme for Recovery and Social Re-integration is organised in two phases: the first is a five month treatment programme; the second offers a six month to two years vocational training programme. The first phase is in two stages: two weeks of detoxification from drugs and four and half months training and counselling interventions (Wellspring Rehabilitation Centre 2003). The purpose of treatment in the first stage is to enable service users to stop drug use and enable them to recover from the physical effects associated with discontinuance of the drugs. Treatment interventions in this first stage include daily prayer sessions, deliverance prayers, and group devotional sessions. The second stage, which is the training period, lasts for 18 weeks. The training is achieved by providing lectures in Biblical Studies, Social Studies and Motivational Studies; Counselling (including group, individual and career), Relapse Prevention and English Language. Other interventions include Bible Reviews, Interactive Sessions and Counselling. The aims of treatment in the first phase are:

- To lead clients to the saving knowledge of Jesus Christ and training in the basic doctrines of the Christian faith aimed at establishing a solid foundation for successful Christian living.
- To train clients to adopt a positive lifestyle and stay off drugs permanently; develop self-efficacy and social responsibility.

- To assist clients develop well balanced goals in order to achieve success in life;
- To modify and build character.
- To achieve productive use of the mind and high level of motivation necessary for the change process (Wellspring Rehabilitation Centre 2003).

The second phase is focused on skills acquisition, preparing service users for a new, drug-free life and for playing a full part in society. At the time of fieldwork, the first phase of the programme was situated at the rehabilitation centre at Ojodu on the outskirts of Lagos, and the second at the vocational centre at Ikeja, Lagos, Nigeria.

Recruitment of service users

Service users are recruited for treatment through advertisement in the agency's newsletter, referrals from churches that provide care for drug-dependent persons in environments where drugs are sold (so-called 'drug joints'), and from parents, pastors and ex-service users. Between 2003 and 2009, 169 persons completed the programme of recovery: 155 males, and 14 females. Fifty people successfully completed the vocational training, and 29 were in the vocational training programme at the time of study. More information on the Centre is provided in appendix 3.

1.11 Structure of thesis

This thesis is made up of seven chapters. The first chapter discusses the motivation, background, purpose and directions for the study. Conceptual underpinnings and background information on the study context are also considered. Chapter two provides an overview of existing literature on the concepts of drug dependence and recovery. The third chapter describes research design and methods employed for data collection and ethical and practical issues arising from the study. It discusses the methods of analysis and the limitations. Chapters four and five contain the findings of the study; chapter four provides the background for the understanding of recovery by exploring the conditions of drug dependency from the viewpoints of informants and the fifth chapter explores the recovery experiences of informants, from dependent drug use. Chapter 6 offers a discussion of the findings, implications for policy, practice and research, and recommendations for further research.

1.12 Summary

This chapter began by providing background information for the study. It identified that the concept of recovery from dependent drug use is not well understood and the aim of the research is to make contributions in this regard. The main research question guiding the study is: 'how do dependent drug persons recover from drug dependence in a Christian faith-based agency? The study design and methods, terms used and descriptions of drug related issues relevant to the study were discussed. The

structure of the thesis was also presented to provide a compass for the thesis. The next chapter provides the context for the study in terms of literature.

Chapter 2 - Review of theory and key research findings

2.1 Introduction

Drug dependence and recovery have been subject to considerable debate in the past and again, more recently. In the early years, theoretical discussion and research investigation focused on understanding the nature of drug dependence, and different explanations led to diverse treatment interventions. There has now been a major paradigm shift, with a new focus on recovery from dependent drug use (White 2007). This review of theory and research is divided into three sections: the first section provides background knowledge of the nature of drug dependence; the second section explores treatment models; and the third section examines understandings of recovery from drug dependence.

2.2 Understanding the nature of drug dependence

There are many different theories which set out to explain the nature of drug dependence. Before the 20th century, explanations were rooted in moral and religious understandings (Segal 1988 : 49). Since then, alternative theoretical explanations have emerged. In this section, the perspectives for understanding drug dependence are grouped into four categories: medical, psychological, socio-environmental and spiritual.

2.2.1 Medical Perspectives

Four perspectives will be examined here: the disease model as well as pharmacological, neuro-scientific and biological explanations.

Disease model

The disease model views disorders from chemical substances as diseases, based on the assumption that 'such disorders have a biological basis' (Segal 1988 : 198).

Pharmacological perspective

The second, the pharmacological perspective, focuses on the properties and reactions of drugs. According to Segal (1988 : 173), early pharmacological explanations suggested that prolonged use of a drug causes physical dependence. This occurs when continued use of a drug over a long period results in increased tolerance, which leads to the use of higher doses. This condition results in changes in the metabolism of cells, the effect being that the user cannot function properly in the absence of the drug consumed. This perspective suggests that substances such as alcohol, morphine and other opiate derivatives, barbiturates, and tranquilizers such as Valium and Librium, possess a high potential for physical dependence. Although offering an explanation for the relationship between prolonged use of some drugs and dependence, this perspective has been criticised for failing to consider psychological and sociological factors in the process of drug dependence.

Neuro-scientific perspective

Advances in neurosciences have enabled a better understanding of drug dependence (O'Brien 2005), therefore, the third explanation focuses on the neuro-scientific perspective of drug dependence. Studies in brain neuro-chemistry suggest that drug dependence is a complex disease of the brain; therefore, explanations for drug dependence focus on the chemistry of the drugs and their effects on the mechanism through which addictive drugs affect the brain. Goldstein and Volkow (2002) note that most studies have concentrated on the involvement of dopamine in the process of drug addiction, drawing attention to the fact that addictive drugs bring rewarding effects for users. For example, Volkow et al. (2002) found that dopamine disrupts the frontal cortical circuits which regulates motivation, drive and self-control and memory circuits, increasing the motivational salience of the drug and associated stimuli. A recent review by Angres et al. (2008), on the disease of addiction, supports this claim by stating that drug studies show that exposure to even one single drug of abuse such as morphine can lead to permanent changes in the brain by affecting memory and creating a process of learning to crave for drugs. However, this perspective of drug dependency has also been criticised. West (2006) argues that there is much uncertainty about the mechanisms in the brain and how far humans can be seen as sharing the same response with rats and mice.

Genetic and physiological factors

The fourth perspective explains drug dependence from biological processes such as genetic and physiological factors. Genetic theory explains drug dependence as a

direct function of genetic transmission, that is, an inherited characteristic passed on from parents to children. Studies of families, adoptees and twins have all shown genetic disposition in drug dependency. Teeson (2002), in her review of the theories of drug dependence, cites examples of genetic studies by Kendler et al. (1997) and Merikangas (1998 & 1990) which suggest that alcohol disorders cluster within families. These studies show that the incidence of alcoholism is more likely to be prevalent among families of those with alcohol problems than in the general population. For example, research by Merikangas et al. (1998) research indicated that over one-third (36%) of the relatives of persons with alcohol disorders were also diagnosed with an alcohol disorder, compared to 15% of the relatives of those in a control group. However, Teeson argues that family studies do not allow a distinction to be made between the effects of genetic and environmental influences. Adoption studies, in contrast, examine the rates of disorder of adopted persons against the disorder rates of their biological and adoptive parents (Teeson 2002). These studies suggest that genetic factors are associated with alcohol dependence. Teeson (2002) points out that research with twins was conducted in order to attempt to separate out genetic and environmental vulnerabilities to drug dependence. For example, a study by Kendler and Prescott (1998) revealed that genetic and environmental factors were responsible for liability to substance use, but genetic factors accounted for heavy use and abuse. Similarly, Kendler (2003) suggested that a common genetic factor was responsible for illicit substance use, abuse and dependence; but shared environmental factors were more responsible for use than abuse and dependence; he found that there were no vulnerabilities towards a specific drug.

Other studies on genetic and environmental influences on substance initiation, use, and problem use corroborate the idea that that there is a connection between genetic factors and problem drug use (Rhee, Hewitt et al. 2003; Kendler, Myers et al. 2007; Kendler, Schmitt et al. 2008). In summary, genetic and physiological studies have argued that there is evidence for the heritability of drug use and dependence.

2.2.2 Psychological perspectives

Psychological perspectives offer another, very different, approach to understanding the problem of drug dependency. These focus on the motives for drug use and the effects of drugs on behaviour. Psychological explanations can be organised around three broad theoretical approaches: those which forefront internal psychological processes **(**such as the trait or personality, psychodynamic, rational choice and cognition); those which are interested in external factors (such as behavioural determinants); and those which see dependency as an interaction between internal and external factors.

Theories which focus on internal psychological processes

One psychological theory, which locates the causes of drug dependence within the individual, is trait theory. This attempts to establish a personality that predisposes an individual to substance dependency. In his research, Segal (1988 : 181-182) identifies that strong dependency needs, emotional instability, low frustration tolerance, depression, impulsiveness, superficial sociability, self-devaluation, and

chronic anxiety are common traits in those with alcohol problems. Other traits, commonly found in those who use heroin, are high levels of anxiety, neurotic and psychotic tendencies. In assessing the usefulness of trait theory, DiClemente (2003) argues that although some traits seem to be common to different substance users, there is no evidence to support a distinctive personality that predisposes people to drug dependence.

A second theory which accounts for drug dependence in terms of internal factors is psychodynamic theory, proposed by Freud, 1856-1939. Howard (2010) suggests that psychodynamic theory is based on the supposition that early experience and unconscious processes combine to create an individual's internal world. She explains that the way a person experiences herself or himself and others, and how she or he experiences and negotiates the external world and overall psychological adjustment, is determined by the conflicts and deficits in the internal world. These assumptions lead psychodynamic practitioners to seek the origins of problems and strive to link the past with the present. From this perspective, it is assumed that what accounts for drug-taking behaviour is an underlying problem or conflict and that drug abuse and alcohol represent a means of escape from internal conflicts; drug dependency is therefore a representation of an underlying emotional problem. This perspective has formed the basis of the psychodynamic counselling approaches employed in the treatment of drug dependence in treatment settings and treatment techniques, which will be examined in section 2.3.2.

A third perspective to understanding drug dependence is proffered by rational choice theorists. These theorists do not support the view that human social behaviour is controlled by unconscious motives. For example, Ajzen and Fishbein, (1980) proponents of the theory of reasoned behaviour, argue that human beings do consider the consequences of their action before they choose to engage or not to engage in a particular behaviour. This theory is based on the assumption that human beings are quite rational and are able to make use of information available to them systematically. West (2006) suggests that from this view point, drug-dependent persons make rational choices in their continued use of drugs; they weigh up the 'pros' and 'cons' and decide that the immediate benefits override the adverse consequences. This view was challenged by cognition theorists such as Weirs and Stacy (2006) who argue that recent research in automatic processes in addiction demonstrate that dependent drug users persist in the behaviour because they cannot control their automatically triggered impulses to use drugs. They claim that 'the problem, often, is not that substance abusers do not understand that the disadvantages of continued use outweigh the disadvantages; rather, they have difficulty resisting their automatically triggered impulses to use their substance of abuse.' (1995: 292).

A fourth perspective is implicit cognition theory. Weirs and Stacy (2006) claim that implicit cognition theory suggests that behaviour is brought about by automatic processes that operate unconsciously. Rooke et al. (2008) propose that aspects of implicit cognition which are found to be related to drug dependence are implicit attitudes, attentional bias, and implicit arousal and memory associations. They define implicit attitudes as spontaneous responses that influence behaviour and attentional

bias as drug cues that automatically captures the users' attention. They also define implicit arousal-related cognition in response to drug cues as automatically activated. Stacy (1995) defines memory associations as drug cues which are related to drug use. In reviewing this approach, West (2006) suggests that although it has been shown that cognition is related to drug dependence, it has not been demonstrated that this represents an abnormality that is responsible for impaired control.

Theories highlighting external factors

A very different approach is taken by those who argue that external factors offer best explanations for drug dependency. Behavioural theories, for example, are based on the principle that all behaviour is learned. There are three major behavioural theories: classical conditioning, operant conditioning and cue exposure theory. Classical conditioning theory was developed by Ivan Pavlov (1849-1936). In his research, he discovered that dogs could be taught (conditioned) to salivate in response to stimuli other than food, such as the ringing of a bell before food was delivered. The importance of this theory in explaining the process of drug dependence and maintenance is that it shows the connection between behaviour and drug dependency; the sight of a needle, the smell of substances, even the drug environment itself might be said to generate conditioned responses.

Another perspective, the operant conditioning model, is derived from the work of Skinner (1904-1990). His theory is based on the proposition that human behaviour is operant because it is affected by consequences of its environment: when the

consequence of a particular act increases or sustains the subsequent likelihood of the act, the act is called a reinforcer; when it reduces the subsequent likelihood of occurrence of the act, it is called a punisher (Glautier (1995). From this perspective, self-administered drugs can either produce positive reinforcement or, perhaps paradoxically, prevent reinforcement. Taking this argument further, Glautier referred to the seeking out and injecting of drugs as an operant behaviour, because the reinforcing effects of the injection maintain it; the act of injection implies that the user experiences drug effects in the presence of distinctive clues, which occur due to the location, the needle, syringe or other factors. Moreover, it is assumed that when those cues are experienced in future, it is expected that they to lead to an operant behaviour such as drug seeking and administration. The operant conditioning model therefore supposes that drug dependence is produced by reinforcement of drugs. Reinforcements are affected by frequency, immediacy, and regularity.

The third perspective explains the role of cue exposure in drug dependency. Drummond (1995) defines a cue as a stimulus that when presented to an animal generates a response which is dependent on the previous experience that the animal has had with the cue. Cues may be those that are present before the actual use of drug such as the smell, sight, taste of an alcoholic drink or drug, or the sight of a needle and syringe. He referred to these as the exteroceptive cues. Cues such as euphoria or anger, and cognitions such as beliefs about drugs effects were referred to as the interoceptive cues. Drummond argues that a cue repeatedly associated with heroin use can be seen as a conditioned stimulus (CS) which results in a conditioned

response (CR); the stronger the association between the stimulus and heroin, the more the likelihood of occurrence and the strength of the CR.

Theories which forefront interactive approaches

Interactive approaches combine internal and behavioural factors in their explanations of dependence. One of these approaches is social learning theory by Bandura (1977). In his early exposition of social learning theory, Bandura suggests that behaviour results from an interaction between persons and their situation; interaction is a reciprocal process between behaviour, personal and environmental factors. This approach supposes that people are not fitted with repertoires of behaviour. Instead, behaviour is learned, and new patterns of response are obtained from either direct experience or by observation (modelling); physical development such as genetics and hormones also play a part in this. Learning by direct experience results from the consequences produced by the action, and positive or successful outcomes are preferred over unsuccessful ones. The consequences of such action influence behaviour by serving informative, motivating and reinforcing functions. From this perspective, Peterson (2002) argues that a person's expectation of a substance (such as feelings of enjoyment or removal of withdrawal symptoms), influences their behaviour; drug using behaviours are learned and perceived self-efficacy or capability can affect behaviour-change positively or negatively. DiClemente (2003) agrees that social learning theory is of particular importance to understanding drug dependence and recovery. He argues that learning theory explains the role of peers and models in influencing behaviour.

2.2.3 Socio-environmental perspectives

In marked contrast to both medical and psychological approaches to drug dependence, socio-environmental approaches focus a person's social environment and the roles which agencies such as the family, peers, society, and environments such as church, school, and neighbourhoods play in dependent drug use. One theory which has been widely used in this regard is systems theory. Systems theory views a family as a social system consisting of interdependent parts, and this system functions properly when other members fulfil their expected roles. When a member fails to fulfil his role, it creates an imbalance which affects other members (Segal 1988 : 189). In this context, problem drug use is viewed as a result of imbalance or stress, or a symptom of stress. Segal suggests that systems theory has contributed to aiding the understanding of the impact of drug-taking behaviour on the family, and the role of the family in supporting and maintaining that behaviour (1988 : 189). For this reason, the systems approaches therefore stress the need to involve the family in any treatment process. However, a longitudinal study by Friedman and Glassman (2000) of an African-American urban community sample which compared risk factors versus peer risk factors for drug use, suggests that family problems had lesser influence on substance use than peer relationships, in the later stages of drug use.

The role of peers in drug dependency has been revealed by several research studies. Cohen (1955) in his theory on subcultures suggests that as participants in a system of social interaction, we deal with our problems by seeking a favourable social milieu when solutions to our problems cannot be resolved within the frame of reference of

the established culture. From this perspective, effective interaction with members of a favourable social group with shared group norms and values is a factor that promotes drug dependency. Segal introduces Johnson's (1980) subculture theory by in support of this argument. In his explanations of patterns of marijuana use, Johnson suggests that subcultures have specific values and conduct norms that control activities around which the group functions and that these conduct, norms and values influence behaviours which promote deviant acts (Segal 1988 : 195). This means that deviant behaviours occur because their reference groups support and reward such actions and this suggests that group conduct is also a factor that promotes drug dependency. Another study identified the influence of peers is by Rhee et al. (2003). This points out that the influence of peers, accessibility of substances and sibling interaction influence substance use. In addition, research by Kuntsche and Jordan (2006) and Lungborg (2006) show that association with substance-using peers have a strong influence not only on individual's drug initiation but also on dependent use.

Another theory, labelling theory, explains societal influence on alcohol dependence. Labelling theory assumes that a deviant act is not an inherited form of behaviour, or even to do with individual motivations and choices. Instead, a deviant act is one which is labelled as such by society. In reviewing labelling theory, Cree (2010:186) suggests that Lemert (1951) made an important distinction between 'primary' deviance and 'secondary' deviance: primary deviance is 'an isolated act of wrong-doing, which may have little significance to the person concerned (for example, a childish prank in the classroom)'. Secondary deviance then occurs 'in response to social reaction to the primary deviance (for example, the child chooses to play the

‘bad boy’ and sets out to annoy or upset the teacher by further rule-breaking)’. She also states that the onset of secondary deviance is viewed by Goffman (1963) as marking the beginning of a ‘deviant career’. Relating labelling theory to drug dependency, (Segal 1988 : 191) argues that since standards are determined by each society, behaviours like cigarette smoking, use of marijuana, and alcohol may be labelled deviant in one society, but not considered as such in another. However, he remains unconvinced that labelling theory offers sufficient explanation of deviance as a whole (Segal 1988 : 191-194).

In addition to these perspectives, environmental factors have been associated with drug-taking behaviours. These include the individual’s immediate environment and the broader system of social organisation such as neighbourhoods. For example, Kendler (2003) argues that environmental experiences unique to the individual (such as home environment) are a major factor in determining whether individuals predisposed to drugs will use or misuse one type of psychoactive drug or the other, rather than peer influence (2003: 693). Furthermore, Boardman et al. (2001) suggest that disadvantaged neighbourhoods are moderately associated with drug use indirectly, through social stressors and higher levels of psychological distress (2001-160). Although, their study emphasised that this is more common to low-income areas, the study by Sunder et al. (2007), in contrast, suggests that the relationship between disadvantaged neighbourhoods and drug use was lower for those living in disadvantaged areas than might have been anticipated. Sunder et al. also suggest that neighbourhood disadvantage may not uniquely influence all drugs, since drug

consumption is also dependent on the cost of drugs and accessibility to drugs (Sunder, Grady et al. 2007).

2.2.4 Spiritual perspectives

Morgan (1999) suggests that explanations for drug use and dependence are rooted in spiritual and religious understandings throughout history. This review will focus specifically on three perspectives: the Christian Pentecostal perspective; the Alcoholic Anonymous (A.A.) and other '12 steps' programmes; and traditional Yoruba perspectives, because each has particular relevance to the study. Christian perspectives provide a background for understanding treatment and recovery within the faith-based model being studied. The A.A. model is well-researched and provides insights into spirituality and drug dependence. The Yoruba indigenous worldview provides an understanding of the concept of disease in the context of this study.

Christian Pentecostal perspectives of drug dependence

Pentecostal Christian beliefs explain drug dependence through the concept of original sin. Other predominant themes in this tradition are centred on ideas of demonic influences and spiritual blindness.

The concept of original sin is derived from the Bible, and based on the story of Adam in Genesis 3. This perspective suggests that all men (that is, all human beings) sin

because Adam sinned; this view is also to be found in the writings of Augustine, and based on Romans 5: 12-21 (2007: 70). Albers (1999: 144) suggests that the consequence of sin is that it creates a gulf between the creator and those who are created. Basing his argument on 2 Corinthians 5:18-19, he suggests that God took the initiative to reconcile the world to Himself in the person of Christ (Romans 5:10), not counting on their trespasses in order for relationships to be restored. There are several implications of this perspective for treatment and recovery from drug dependence. The first is that recovery is dependent on a relationship with God, who can do and does what human beings cannot do for themselves (Albers 1999: 143). It is assumed that God desires reconciliation and is determined to be in a relationship with human beings, regardless of what they have done or who they are; God's acceptance of man is significant in the recovery process. Furthermore, man's submission to God and nurturing of the spiritual/relational life with God, and relationship with others are said to be important to the recovery process (1999: 143-146). Larsen also argues that the two greatest needs of every person are to love and be loved, and acceptance. He suggests that recovery comes about from the healing of wounds inflicted by addictions such as denial of love. From this perspective, sickness is regarded as a result of inherited depravity; it comes from the devil and its cure, then, is atonement. Quoting Carter (1884), Alexander defines atonement as 'pardon from past sins, and past uncleanness (sic); and cleansing from all traces of inherited depravity, as well as the keeping power against sin in any form, outward or inward. The vicarious atonement of Christ is explicitly for all depravity, including sickness.' (2006: 42). Based on this understanding, atonement provides for pardon from the penalty of sin, the power of sin and healing from sicknesses. In this regard,

Alexander explains that healing is a gift of God's grace. The belief of the Redeemed Christian Church of God on sickness fits into this perspective. It claims that sickness is a result of the fall of man (based on Genesis 3: 1-16 and divine healing of sickness for believers is provided in the atonement (based on Matthew 8: 15-17) (The Redeemed Christian Church of God 2011). This perspective informs the practice of the offer of salvation and divine healing as interventions for sicknesses, which includes drug dependency.

Furthermore, the concept of sin may provide a better understanding of the concept of original sin. There are three ways in which this has been viewed. First, it has been viewed as 'anything in the creature which does not express, or which is contrary to the holy character of God the creator' the underlying factor being living independently of God, based on Romans 3:21- 8:39 (Zondervan Publishing House 1976: 557). Second, Gunton suggests that sin is the disruption of relations between man (sic) and God (2002). Third, Higton further suggests that anything in human activity that stand in the way of salvation (Higton 2008).

A second perspective is the concept of demonic influences. The doctrinal beliefs of the R.C.C.G. suggest that that there is a devil who has several unclean spirits under his control and who tries to bring people down. (The Redeemed Christian Church of God 2011). This understanding informs the treatment practices of Christian Pentecostals who engage in deliverance prayer as an intervention for drug dependence and other related problems. Not only this, Brakeman, writing on Biblical

theology of addiction defines demonic possession as, control by an evil external force not within the person's control (Brakeman 1999). Drawing from the story of the possessed man in the Bible (Mark 5:35), she explains that demonic possession is a condition in which the person is out of control, in torment, constantly hurting oneself, and living out in tombs. She suggests that addicts are dominated mind, body and spirit by something outside their control. Since dependent drug user has no control over substances the person is unable to make changes even though negative consequences are experienced in some or all areas of life such as spiritual, emotional, vocational, economic, relational, legal and medical. The condition she suggests, spiritually represents being in sin, which means disconnection from God and others in a deep way. She suggests that people who are possessed do not have control and are unable to help themselves; therefore, they need the invention from a power greater than themselves (1999: 195-198).

Another perspective is the concept of spiritual blindness which Wagner (1991) explains from Corinthians 4:4 that Satan blinds the minds of people (that is, prevents people) who do not believe from knowing God. Lawson (1991) said that we live in the midst of real-life spiritual warfare involving invisible forces like demons, Satan, angels, the Holy spirit of God and man on account of the salvation of human beings. He suggests their domain can include a household, a neighbourhood, a city, a nation, a culture and a subculture. He bases his argument on Ephesians 6:12 which provide insights into the struggle against principalities, powers, rulers of darkness of this world and spiritual wickedness in high places.

The A.A. Perspective of Drug Dependence

Albers suggests that historically, drug addiction was viewed as a holistic disease which affects the totality of the person: body, mind and spirit as well as the environment in which the person lives (1999: 139). Proponents of this perspective are the A.A. and other 12 steps mutual aid groups. The A.A. was founded in 1935 by Bill Wilson and Dr Bob Smith. (Alcoholics Anonymous World Services 2009). Morgan, suggest that founders of the A.A. believe that alcoholism is a disease, as suggested by the medical model, although with a difference. They suggest that drug dependency is a triple disease of the body soul and mind, that is, a physical, psychological and spiritual disease (Morgan 1999: 8-11). The 'Big Book' of the A.A. claim that alcoholism is a disease of the body and the mind and the solution is through a spiritual experience: it lies in accepting the hopelessness and futility of life of an alcoholic, unconditional surrender to a higher power, forming a relationship with the living creator, experiencing spiritual growth and reaching out to other alcoholics. This relationship to a living creator was referred to as a personal affair (Alcoholics Anonymous 2007: 9-10, 21-26, 33-45).

The indigenous Yoruba perspective of drug dependence

The indigenous Yoruba worldview and the concept of illness provide understanding on their perspectives of drug dependence. Awolalu (1979: 4) suggest that the Yoruba people believe in the existence of a supreme being, who is believed to have created the earth, humans, and spirits. The spiritual cosmos consists of benevolent and malevolent forces. According to Abimbola, the Orisa, (also known as four hundred

supernatural forces on the right) are benevolent to human beings and endow blessings such as money, children and good health. The Ajogun, (also called two hundred supernatural powers of the left) are malevolent forces who take interest in destroying people and their work. Ill health and disease are sometimes attributable to the malevolent forces (Abimbola 1994:101-111). Arun (disease) and aisan (sickness) is perceived as part of the 200 malevolent forces. This helps to explain the spiritual etiologies of illness. Thus drug dependence or mental disorder becomes an illness. Abimbola points out that the Yoruba believe that good character (iwapele) will prevent a person from being afflicted by the malevolent forces.

Furthermore, Abimbola states that the traditional Yoruba believe that a person can experience misfortune (which may include sickness and disease) through predestination, humans experience misfortune. He explains that the Yoruba believe that human beings possess a physical part called *ara* and a spiritual part called *ori destiny)*. It is believed that *ori* determines the good fortune of an individual on earth such that an individual who is born with a bad *ori* will have misfortunes in life and will constantly need to make sacrifices in order to appease the deities.

The Yoruba also ascribe the cause of sickness and disease to ancestors. Westerlund (2006: 121-148) in his work on '*African indigenous religion and disease causation'*, also claims that ancestors and other spirits may be referred to as sources of sickness. He however suggests that divinities are the most important causal agents of disease. In addition, Awolalu (1979) claims that to the Yoruba, 'nothing happens by chance';

it is assumed someone, directly or indirectly must be responsible by the use of powers (such as witchcraft, incantations and magic) (1979: 91).

These views imply that any abnormality, which includes drug dependence, may be attributed to a number of spiritual factors such as disharmony between the dependent user and the ancestors, divinities responsible for sicknesses, witches, sorcerers, from curses inflicted on the drug user, from a bad 'ori', and bad character. Omonzejele on '*African Concepts of Health and Disease*' confirms this assumption stating that to the Africans, the cause of diseases goes beyond the malfunction of the physical organs of the body. He claims that when a person takes ill, the traditional practice is that priests who serve as medium between the human and superhuman worlds, are consulted to determine the cause of the illness but intervention in form of sacrifices is made whether it is ancestrally linked or not, and atonement is sought if it is related to spiritual factors. (Omonzejele 2008:121). The implication of this worldview for the study is that as Omonjeze suggests, Africans tend to be spiritually inclined, that is in their perception of and treatment of disease. This has great implications for understandings of drug dependence and treatment within the African context.

2.2.5 Summary of understandings of drug dependence

From the above review, it is evident that there is no consensus on the understandings of drug dependence. Medical studies view drug dependence as physiological disease and a disease of the brain, psychologists focus on personal and interpersonal factors, socio-environmental studies account for drug dependence from the association

between family, peers and the environment; and spiritual perspectives account for this in terms of moral, spiritual deficiency and influences. These different views provide a general context for understanding drug dependency. The next section reviews major treatment approaches.

2.3 Approaches to treatment from drug dependence

Practical interventions for treatment of drug dependence are varied and rooted in the different theoretical propositions already examined. The interventions reviewed in this section are medical, psychological, socio-cultural and environmental and spiritual.

2.3.1 Medical approaches

Medical approaches to drug dependence treatment are based on the understanding that drug dependence results from neurobiological and neurochemical underpinnings (Heidbreder 2005). According to Merrill (2002) the aim of medical. treatment is to assist patients discontinue or decrease the use of drugs, and avoid or reduce harm caused by drug use. Furthermore, Merrill (2002) identifies three strategies employed for the treatment of dependent drug use: detoxification, relapse prevention, and maintenance, and these often overlap in practice. Detoxification is a process which aims to achieve abstinence without experiencing withdrawal symptoms by using pharmacological equivalent drugs and gradually reducing the dose of the drugs (Bisaga and Popik 2000). Three methods of detoxification described by the Royal

College of Psychiatrists (2000) are gradual detoxification, abrupt withdrawal, and accelerated detoxification. Relapse prevention is carried out in treatment settings through pharmacological treatment in combination with psychological approaches to help manage the desire or cravings for consumption of the drug /drugs that the user consumes. Maintenance entails prescription of substitute drugs designed to block the effects of the drugs abused. Some of the substitute drugs which are found to be effective are: methadone, leoacethylmethadol and buprenorphine for the treatment of opiates; naltrexone, acamprosate and aversive agents like disulfiram for managing alcohol dependence; and nicotine replacement therapies such as nicotine patch, nicotine gum, nitcotine nasal spray, nicotine vapour inhaler and the nicotine lozenge (Heidbreder 2005). However, Heidbreder claims that research suggests that there are no known effective pharmacological strategies for the treatment of cocaine and other stimulants. In the U.K., the National Institute for Health and Clinical Excellence (2007) states that pharmacological approaches are the primary treatment for opioid misuse and dependency, supported by psychosocial interventions. In addition, the report supports earlier claims that treatment for stimulants and cannabis are not well developed, and hence the reliance on psychosocial interventions.

Another strategy is harm minimisation, also known as harm reduction. Robertson (1998) pointed out that although abstinence is recognized as the best approach, immediate or even long term may not be possible, there is the need to reduce the harm associated with drug dependency. Furthermore, Pates (2002: 121) argues that harm minimisation is based on the understanding that drug-dependent users will continue to use drugs despite the risks or prohibition and it is supposed that these

risks can be reduced or minimised. Therefore, harm minimisation is often referred to as risk management in relation to drug use (World Health Organization 2006). Pates explains that harm minimisation entails educating drug users about the risks involved in drug taking and assisting them to take responsibility for themselves. Treatment interventions include substitute prescribing programmes; relapse prevention training; and provision of needles, syringes, condoms, and services for testing for infection, aimed at minimising harm through reduction of the transmission of HIV, hepatitis and other infectious diseases by dependent drug users.

Reviews of international and UK effectiveness studies indicate that drug treatment is effective in the following ways: it has a positive impact on levels of consumption by reducing consumption, offending, overdose risk and blood- borne viruses during and after use; and assists in general improvement in health (Robertson 1998; Pates 2002; World Health Organization 2006; Department of Health (England) and the devolved Administrations 2007)**.** In addition, research by Gossop et al.(2001) shows that about 35% of clients on methadone programmes were abstinent from opiate use. However, Ashton suggests that evidence provided by the National Treatment Agency (NTA) for Substance Misuse in England, in 2006/2007, points out that the number of persons in treatment who have recovered is low (2007). This prompted a review of the management of problem drug use from treatment to recovery-focused management, by the UK and Scottish Governments (The Scottish Government 2008; HM Government UK 2010). Review of drug treatment for 2009-2010 by the NTA in the UK shows that there was a reduction of overall number of adults that were dependent on heroin and cocaine (National Treatment Agency for Substance Misuse

2010). This suggests that more people who received treatment have recovered. In addition, a long-term outcome study by the NTA (2010) of persons who received treatment for one year (2005-2006) claim that 46% of those of those who received treatment do not need treatment and were not found to be involved in offending. Furthermore, the NTA (2011) on Drug Treatment and Recovery shows that there was a significant increase of 150% (27,967 persons) of those who have recovered, compared to 2005-2006.

Reviewing the evidence as a whole, it seems that medical treatment approaches to recovery assist drug users in two ways: first, by reducing harm and improving health in the short term to most drug users, and second, by helping those who complete treatment to achieve sustained recovery in the longer term.

2.3.2 Psychological approaches

Psychological treatment approaches, as would be expected, are based on psychological understandings of drug dependence. These treatment models focus on behaviour change and are often applied in combination with pharmacological therapies in relapse prevention. They also offer alternative treatment options for patients who do not want to be on daily medication. The major psychological treatment modalities are cognitive-behavioural approaches, motivational interviewing and counselling.

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is based on conditioning and operant learning principles. This suggests that what affects behaviour are the ways in which events are interpreted and the beliefs individuals have formed about their experiences; the aim of treatment is therefore to change maladaptive thoughts which contribute to inappropriate behaviour (Bennett 2002). Jarvis (2006) suggests that there are six cognitive behavioral strategies: cognitive therapy, problem solving, drug refusal, assertiveness, communication, and relaxation training. Cognitive therapy is aimed at helping clients identify and challenge beliefs or thoughts that promote substance use and replace them with positive ones. Problem solving skills training is focused on enabling clients recognise when a problem exist and provide solutions to the problem. The intention of refusal training is teaching clients to refuse offers of drugs appropriately, in an assertive way. In addition, the goal of assertiveness training is to enable clients deal with situations appropriately, that is, not being under-assertive or aggressive. Communication training skill is directed at enabling clients to initiate and continue conversations, cope with silences and listen to others. Relaxation training is aimed at assisting clients to recognise and release tension such as physical, psychological and mental. According to WHO (World Health Organization 2009) the commonly used methods of CBT are cognitive therapy and motivational enhancement therapy. Cognitive-behavioural intervention is mostly used in combination with drug maintenance treatment for relapse prevention in treatment settings in the U.K. Based on the U.K. evidence, Wanigaratne et al. suggests that CBT, is a useful intervention for stimulant and cannabis misuse and in relapse prevention (2005:4). The report by the Department of Health (2007) also claims that

it is to be an effective intervention. However, the report suggests that when this therapy was applied to patients with alcohol problems, a significant number of people in the treatment programmes experienced on-going difficulties. Therefore, it was recommended that self-help and mutual aid groups should be recommended for clients who wished to achieve and maintain abstinence.

Motivational Interviewing

Motivational Interviewing (M.I.) is a counselling style for eliciting behaviour change. Peterson and Davies (2002) suggest that behaviour change is achieved by assisting clients to probe and work out problems regarding their ambivalence to change. This approach assumes that since motivation is fundamental to change, clients' level of motivation for change is often a good predictor of outcome. According to Miller and Rollnick (2002), the primary causes of change are not humiliation, shame or guilt; instead constructive behaviour-change is triggered 'when the person connects with something of intrinsic value, something important, something cherished' (2002: 12). Further, they suggest that 'intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued' (ibid.). From this perspective, what matters is therefore to explore and follow what the person is experiencing from the perspective of the client.

In a review of studies on the effectiveness of M.I., Heather (2005) claims that M.I. has been scientifically tested and proved to be a useful intervention strategy in the

treatment of alcohol and drugs, particularly with patients who are not seriously dependent on drugs and those who do not want formal treatment. Moreover, due to its emphasis on clients deciding and taking responsibility for change, it has also been particularly useful in brief interventions and harm reduction interventions. However, Heather acknowledges that there is little evidence to show that it is a superior intervention when compared to others. In the treatment of substance abuse and dependence, the U.K. evidence suggests that M.I. is particularly effective in addressing stimulant and cannabis misuse (Wanigaratne, Davis et al. 2005: 4).

Counselling

Counselling, like other psychological approaches employed in the treatment of drug misuse and dependence, is aimed at facilitating behaviour change and resolving co-existing disorders that are associated with drug use such as anxiety and depression. There are two major counselling interventions: psychodynamic and person-centred approaches. Howard (2006) defines psychodynamic approaches as all models of the mind that are primarily concerned with unconscious processes and these models have their origins in the work of Freud (1856-1939) and psychoanalysis. Howard suggests that the key concept in psychodynamic counselling supposes that we all have an unconscious inner world that has a strong influence on the way we think, feel and behave. In practice, psychodynamic counsellors assist clients to become aware of their inner world, and to make conscious and explicit as much as possible of the mind's workings, which were previously unconscious and implicit (Howard 2006). Furthermore, Howard later suggests that one of the aims of the therapy is 'to make

sense of the past and disentangle it from the present' (2010: 2). Another aim is to aid the client's own capacity for self-repair, and in such a way that the client can continue to maintain his/her emotional development without the physical presence of the counsellors. (Howard 2010: 2). The strategies employed in psychodynamic counselling include the therapist's ability to receive, track and interpret the client's inner world, paying careful attention to setting; that is, by providing a 'reliable, consistent unobtrusive environment' in order to facilitate working with the client's unconscious world (Howard 2010: 2). Relating this to drug dependence, Miller (2005) suggests that since addiction is a consequence of conflicts and motives which are unconscious, the therapist attempts to make individual's unconscious motives conscious. This is achieved by helping clients to work through their conflicts through transference and counter-transference. Miller describes transference as the client communicating to the counsellor and counter-transference as the personal issues arising. Psychodynamic counselling has been offered on both a group and individual basis (World Health Organization 1993).

The second approach, person-centred counselling (also known as non-directive counselling), was developed by Carl Rogers (1902-1987). Rogers challenged the beliefs of psychoanalysts and behaviourists, the two major psychological approaches in his time, because he considered that in both approaches, the therapist set himself up as the expert who diagnosed clients' problems, set goals and directed how these goals were to be achieved; in contrast, clients were presented as helpless and had no choice and control over their behaviour (Casemore 2006). Rogers believed that clients know what and where the problem lies, and what is best for them. He

suggested that the task of the counsellor was to guide their client to experience the right growth-promoting conditions in the counselling relationship, one that would enable clients to access their own strengths and find self-direction. Rogers claimed that the aim of the person-centred counselling was not to solve problems, but to develop a trusting relationship such the counselee would be able to grow, cope with and solve problems effectively and function more effectively (Casemore 2006). In line with this proposition, Miller (2005) suggests that strong therapeutic relationship is important to assist a client become sober. Another therapy is about helping clients to focus on the present moment. This involves breaking up the period of sobriety into time segments. This method is said to assist the client to manage the challenges associated with staying sober such as difficult memories of the past, stressful events occurring and fear of the future.

It is important to note that the counselling approaches reviewed above are secular counselling interventions. Several studies have acknowledged that there is a connection between spirituality and physical and mental health and well-being (Shanfranske 2005). Because of this, there is increasing evidence of the inclusion of spirituality in counselling practice (Cobb and Robshaw 1998; Dermatis, Salke et al. 2001; Hartz 2005; Furness and Gilligan 2010). This is very relevant to the present study; spiritual treatment approaches are reviewed in section 2.3.4.

2.3.3 Socio-environmental treatment approaches

Socio-environmental treatment approaches include residential and mutual-help models of treatment of drug dependence. This section will review two popular models which offer residential support, before turning to mutual help models.

Residential models

Two popular residential models are the Minnesota model and the Therapeutic community model (T.C.).

The Minnesota model developed in the Unites States in the 1940's and 50's, with the founding of three residential treatment centres: Pioneer house, Hazelden and Willmar state hospital. The model is a comprehensive abstinence-based model, founded on the principles of Alcoholics Anonymous (A.A.) (Cook 1988). According to Cook (1988), there are four key elements to this approach:

- A belief that drug-dependent persons can change their beliefs, attitudes and behaviours.

- An acceptance of the disease concept, that is, that addiction is a disease, not a neurological or pharmacological problem.

- The idea that treatment has two long-term goals and four short-term goals. The long-term goals are abstinence from all mood-altering chemicals and improvement of lifestyle. The short-term goals are focused on recognising the

illness and consequences; accepting that help is needed because the disease cannot be cured and managed constructively; identifying the need for change so that the illness can be lived with in a constructive manner; assisting patients to make the necessary changes to increase their level of functioning and to develop a new lifestyle.

- The principle of the '12 steps', with an emphasis on the idea of a higher power, reconstructing relationships with other people, confession, restitution and helping others.

Cook also suggests that the treatment model should be understood in three stages. The first stage is assessment and admission to a residential home for duration of three to six weeks in the US and six to eight weeks in the UK. The second stage is progression to an intermediate residential care or half- way home. The third stage is the outpatient and after care that includes the attendance of A.A./N.A, counselling, individual and group therapy and intensive family programme. The Minnesota model is said to meet the needs of different categories of people, including women and children (Cook 1988; World Health Organization 1993) .

Reviewing the effectiveness of the model, literature suggests that the Minnesota model is associated with positive outcomes for patients who complete treatment (Cook 1988; Winters, Stinchfield et al. 2000; Harrison and Asche 2001). Winters et al. (2000) compared outcome data at six months and 12 months among three groups

of 245 adolescents: those who completed treatment, those who did not and those on the waiting list. Their findings suggest that those who completed treatment had better outcomes than those who did not complete or receive treatment; 55% of those who completed treatment reported abstinence, as compared to 15% and 25% for the group that did not complete treatment and the group on the waiting list, respectively. In addition, their frequency of use during the follow-up period was less, from intake to post-treatment period. The study also revealed that a short stay in treatment was not much better than not having treatment. Harrison and Asche (2001) carried out an outcome study based on 3,670 adult outpatients and 1,283 adult inpatients and 214 adolescent outpatients and 173 adolescent inpatients. 64.5% adults and 83.5 % adolescents completed post-treatment interviews. Findings showed that a higher percentage of adults (59.5 of inpatients and 63.8% of outpatients) reported abstinence from alcohol and drugs in the six months after treatment. However, a lower percentage, 21.4% of adolescents were abstinent. Apart from abstinence, adults and adolescents showed significant improvements in their general health. In addition, it was found that both inpatients and outpatients who completed treatment were most likely to achieve abstinence. A common predictor of success in adults was having a close relationship; for adolescents, predictors of abstinence included legal restraints, parental monitoring and being female.

Therapeutic communities (T.C.) also play a significant role in the treatment of drug dependency. Examples of therapeutic communities are Daytop International and Phoenix House in the U.S.; Odyssey House in Australia; and Ley Community, Oxford and Alpha House in the U.K. De Leon (1994) reviewed the basis for the T.C.

model of treatment and suggests that therapeutic communities rely on the community as the primary intervention and recovery for drug dependency and to bring about change in drug-taking behaviour**.** The emphasis of the community model hinges on mutual, self-help and role modelling by peers and staff. The constituents of a community are the philosophy and beliefs of the T.C., an environment set apart for T.C. objectives, a daily structure that explains member roles and an integration of rewards and sanctions (Tims, Jainchill N. et al. 1994; Perfas 2006). Goals of treatment include relations and safe lifestyle, development of new values maturity and responsibility; encourage healthy interpersonal relationships; and bring about psychological changes such as change in negative behavior, and attitudes such as behaviour, feelings and thinking (Daytop International 2006; Perfas 2006). T.C. interventions include a behaviour-shaping/management modus; psychological and spiritual methods and self-competency enhancement exercises.

Evaluation of effect and outcomes of therapeutic communities by Daytop International (2006) using four measuring scales (level of drug use, criminal behavior, employment or productive activities and psychopathology), revealed that treatment retention is the best predictor of outcomes of treatment and positive treatment results from a minimum of six months of residential care. It was noted that the most critical stage of care for treatment is within 30-60 days when clients are likely to drop off from the treatment programme and the improving retention poses the greatest challenge and development of effective intervention to arrest premature

drop out from treatment programme. De Leon et al. (2000) agrees with these findings and also suggests that successful outcome is related to length of stay.

Mutual-help groups

Mutual help groups are peer-led groups that assist individuals and families in initiating and maintaining recovery from problem drug use (McKay, Carise et al. 2009; White 2009). This is achieved through group ideologies and by providing emotional, social and informational support. They also assist members to assume responsibility for their alcohol and drug problems, for sustained health, their well-being and recovery (Center for Substance Abuse Treatment 2008). The strategies for recovery are brought about by recovered individuals through instruction, confrontation, shared experiences in groups, and as supportive friends and role models (George 2004).

Literature suggests that mutual-help groups have different approaches and these can be classified into three. The first category consists of groups who share the ideology of the 12 step principles of Alcoholic Anonymous (A.A.), viewing themselves as spiritually-based fellowships (Faces and Voices of Recovery; World Health Organization 1993; Chappel and DuPont 1999; Center for Substance Abuse Treatment 2008). The second category consists of faith-based fellowships that do not adopt the 12 steps principle. A third category comprise of non-faith-based or secular groups. Some of the groups that share the 12 steps principles are Narcotics Anonymous (N.A.), Cocaine Anonymous (C.A.), Crystal Meth Anonymous,

Alcoholics Victorious, Chemically Dependent Anonymous, Heroin Anonymous, family-based groups such as Co-Anon Family Group for cocaine dependency and Nar-Anon family groups, Marijuana anonymous, Methadone Anonymous Support, Nicotine Anonymous (N.I.C.A.), Advocates for the integration of recovery and methadone, inc (A.F.I.R.M.), Recoveries Anonymous (R.A.) and Millati Islam (Faces and Voices of Recovery; Center for Substance Abuse Treatment 2008). The 12 step approach places emphasis on abstinence and 12 developmental steps to recovery from drug dependency. Other components of the model are the sharing of narratives and helping of others. The non-12 steps faith-based groups include Christian groups such as Alcoholics for Christ, Addictions Victorious, Celebrate Recovery in the U.S.; the Calix Society which is an association of Catholic alcoholics, and Buddhist Recovery Network (Faces and Voices of Recovery). Since the 12 steps and faith-based are spiritually based fellowships, these are discussed under spiritual models of treatment.

Regarding the effectiveness of mutual aid groups, many studies claim that self-help approaches to treatment of drug dependence are effective. For example, Kissin et al. (2003) examined the longitudinal relationship between self-help group attendance and levels and patterns of use of alcohol and other drugs over a period of 30 months, in a sample of individuals seeking treatment from substance abuse in a public treatment system. Findings of this study suggest that self-help attendance was associated with reduced alcohol and drugs over time; individuals who attended meetings continuously reported lower levels of alcohol and other drug use at follow-up than those who either attended intermittently or did not attend. Furthermore, the

Center for Substance Abuse Treatment (2008) states that research on mutual-help groups shows that active involvement in the groups significantly increases the likelihood of maintaining abstinence. In addition, abstinence rates increase with greater group participation and group attendance was associated with lower levels of alcohol and drug-related problems. Furthermore, White (2009) states that participation in mutual-aid groups improves long term recovery rates, global functioning and reduces post recovery costs. He also suggests that combining mutual aid with clinical treatment improves outcomes. However, he noted that individual responses to recovery are different.

2.3.4 Spiritual approaches to treatment of drug dependency

Several spiritual models of treatment from drug dependence are discussed in the literature. These include Christian treatment models, Islamic treatment models, Asian traditional models, Native American and African traditional perspectives. Three approaches are discussed here because of their direct relevance to the PhD study. These are Pentecostal Christian model (for example the R.C.C.G), indigenous non-Pentecostal churches' (Aladura) treatment of drug dependence, and Yoruba indigenous traditional models of treatment.

Pentecostal Christian models

Pentecostal models for treatment of drug dependence are based on the concept of salvation from sin, the idea of divine healing and other Bible doctrines. The

Redeemed Christian Church of God (on which the Wellspring Rehabilitation Centre is based) exemplifies this approach.

Alexander explains salvation from sin in Wesleyan terms. For Wesley, salvation meant freedom from 'past penalty of sin, present power of sin and future presence of sin' (Alexander 2006: 41). In addition, Odeyemi (2010) suggests that salvation embraces three concepts: to be saved, salvaged and redeemed. From a scriptural basis in the bible, in Revelations 4:7, being 'saved' meant removing that which hindered a person from fulfilling God's purpose in his life; it was also viewed as a deliverance from sickness and physical infirmities (see Mark 5:23, 28; III John 2). Being 'salvaged', in contrast, meant deliverance of mankind (Exodus 2: 23-25; 3: 7-9; Isaiah 5:1-7; Ezekiel 34:11-31; Genesis 1:26-28). Being 'redeemed' described the actual work of salvation by God, through the substitution of Jesus Christ as ransom for sin (Ephesians: 7; Galatians. 3: 13). Researchers have explored the ways that salvation has been experienced and written about. For example, Asamoah-Gydu (2005) studied Charismatic churches in Ghana. He found that those who followed a Charismatic faith believed that salvation brought 'transformation and empowerment, healing and deliverance, and prosperity and success in the lives of believers' (2005: 133). The transformative experience came about by the Holy Spirit; evidence of this was said to include speaking in tongue, prophecies, visions, healing and miracles in general. Salvation was said to be achieved through the confessing of sin, inviting Jesus into their lives and developing a new intimacy through Christ (2005: 137). Torrey (1974) has also written about the role of the Holy Spirit in salvation. He describes the Holy Spirit as 'a divine person of infinite majesty, glory and holiness'

(1974: 10), asserting that the Holy Spirit dwells in the hearts of believers every day, and is a loving friend, ever-present and mighty helper. Torrey believes that a Christian experience is transformed when a person comes to know the Holy Spirit as a divine person; a person who receives salvation is transformed to be like Christ and grows in grace increasingly.

Turning to divine healing, Alexander explains that Pentecostals believe that any type of physical disease can be cured by the supernatural intervention of God through the prayer of faith, made available as a part of salvation (2006: 9). Pentecostal healing intervention occurs in two ways: first, in meetings where instructions in holiness, healing, and prayers for the sick are offered, and second, in residential institutions, or so-called 'healing homes' (2006: 54-58). Ojo outlines two types of healing, physical healing and healing from demonic attack or oppression (2006: 201). The Bible describes several ways through which divine healing can be obtained (Hagin (1979). These are: using the name of Jesus against the devil and demanding that the sickness and disease leave (Acts: 3 & Mark 17;17,18); praying to God for healing in the name of Jesus (John 16:23, 24); prayer of agreement (Matthew 18:19); anointing with oil (James 5:14); by the laying on of hands (Mark 16:16-18); through gifts of healing individuals endowed by God with gifts of healing (1 Corinthians 12:9); by individuals who know that healing belongs to them and appropriates this (1 Peter 2:24) (Hagin 1979:39-62). Other ways in which divine healing can be received are through the blood of Jesus (Ojo 2006:200-201), sanctification (2006:53) and quickening of the Holy Spirit (Asamoah-Gyadu 2005:135). Furthermore, healing for

demonic oppression is achieved through deliverance prayers (Wigglesworth 1982; Ukah 2008: 198; Ali 2009).

The R.C.C.G. (2011) believes that the way divine healing is received is in line with Bible scriptures such as individual prayer (John 14:13-14), prayer of agreement by who have agreed to pray by faith (Matthew 18:19-20), and through laying on of hands by the elders of the church anointing the sick (James 5:14 -15). The church also believes that to obtain divine healing (that is, healing without the use of medicine), believers must live a sanctified life (Romans 6: 13-19). Sanctification means consecrating one's life to God (Adeboye 2002).

On the effectiveness of Pentecostal Christian approaches to drug treatment in Nigeria, Adelekan suggests that faith-based agencies as a whole claim a high abstinence rate of up to 70% six months after discharge, a low re-admission rate and full social re-integration of most of their service users (Adelekan 2000: 34-36). Outcome indicators were total abstinence from drugs, successful vocational re-habilitation, social-re-integration and increased participation in religious activities. Moreover, a review of outcomes evaluation in faith-based services by Ferguson et al. (2007) in the U.K. reveals that faith-based programmes have positive influences on a variety of outcomes such as substance abuse, health, criminality, education, employment and wages, and psychological skills. Findings show that these include achievement of sobriety, likelihood of clients remaining sober overtime, lowering of crime rates, increased self-confidence and self-concept and improvements in overall quality of

life. The study further suggests that when compared to secular services, participation in faith-based programmes has a positive impact on influencing overall health values and lifestyles (Ferguson, Wu et al. 2007: 271-272).

Treatment models of non-Pentecostal Independent African Churches in Western Nigeria

The independent African churches are known as Aladura churches. Although available literature is not specific on treatment for drug dependence, there is information available on interventions for sickness in general. For example, writing about the Celestial Church of Christ (an Aladura church), Adogame (1999) tells us that prayers are believed to resolve all types of problems, including sicknesses. This reflects the church's worldview, that is, a belief in the existence of benevolent and malevolent forces. Prayer rituals are carried for two reasons: to attract the benevolent forces on the one hand, and to repel malevolent forces on the other. Prayers often start with the invocation of the name of God, Jehovah, Jesus Christ and St. Michael (who is believed to be the head of angels) to bring down spiritual power. Further, prayers are offered with praise during the invocation of benevolent powers to attract divine blessings, all good things in life, mercy and spiritual power. Adogame suggests that the efficacy of prayer hinges on how this is communicated with spiritual recipients; therefore members are urged to make decrees when praying. Prayers are offered on collective basis within the church and on an individual basis. In addition, special prayers are offered in response to specific needs or to a prophetic message. Adogame also explains that when receiving special prayers for specific issues, it is common practice that the individuals concerned are confined in the

church, where they undergo fervent prayers. Duration of stay is dependent on the nature of the problem and spiritual work required. In addition to prayers, other rituals include the use of holy water, usually obtained from a well dug in each parish for therapeutic or prophylactic purposes. It may be used as a purgative, consumed to heal physical ailments and restore spiritual powers, sprinkled to drive away malevolent forces and used in bathing after being sanctified through prayers. Another type of water given to clients to drink for therapeutic purpose is green water called 'omi agbara'. It is believed that this water serves as a purgative from impurities, harmful substances (Adogame 1999:182). The use of blessed water is also familiar to the Zionist or Ethiopian Church, and in the case it used for the treatment of drug dependence (World Health Organization 1993). Other methods include injunctions against the consumption of substances of abuse, admission of personal problems, physical and spiritual purification and counselling.

Yoruba indigenous religious models of treatment for drug dependence

Odejide et al. (1989) suggest that the treatment of alcohol abuse in traditional African society also reflects indigenous beliefs about mental disorders, which are believed to be caused by external agents such as malevolent spirits. Therefore, healers view alcoholism as a curse and treatment is directed towards eliminating the curse. (Odejide, Ohaeri et al. 1989:248). In line with this view, drug dependency is believed to be caused by external forces. Treatment intervention is aimed at cleansing the individual through performing ceremonies of rituals by traditional practitioners in traditional healing homes. This involves shaving off a person's hair,

making incisions on the scalp and rubbing some powder into the wound. This serves as an antidote to the curse when it enters the bloodstream. In addition, sacrifices are made to the identified malevolent spirit and the patient's head is washed in a flowing stream. It is believed that by this act, the evil spirits flows away in the stream. During the period of treatment (which lasts for between 6 months to one year), the patient is expected to be abstinent from alcohol. Traditional healers believe that anyone who completes the treatment process will be fully cured of their drug habit. However, Odejide et al. point out that many patients do relapse. They also suggest that there is no follow-up in place in this treatment approach.

2.3.5 Summary of treatment models and implications for recovery

Four main treatment approaches were reviewed: medical, psychological, socio-environment and spiritual. Findings from evaluation studies revealed that the treatment models have various degrees of effectiveness and roles in recovery. Evidence showed that a medical approach is effective in harm reduction; psychological approaches are helpful in relapse prevention; and socio-environmental and spiritual models have a contribution to make in achieving and maintaining sobriety. Moreover, spiritual models seem to be effective in influencing positive health values and lifestyles of those who participate in their programmes. Hartz (2005) suggests that spiritual approaches to treatment are gaining more recognition because of the limited extent to which pharmacological and psychological therapies can assist clients to change and flourish, and because multicultural factors are now an essential part of clinical work, with spirituality being seen as an essential part of a person's cultural world. Therefore this approach needs to be researched more in order to assess its contributions to recovery. The next section of this chapter provides a review of models of recovery from drug dependence, in order to show the relevance for research.

2.4 Approaches to recovery

As in earlier sections, medical, psychological, socio-environmental and spiritual perspectives are discussed. Research has also shown that drug-dependent people recover without treatment (Stall and Biernacki 1986), therefore, this will also be explored within the broader discussion.

2.4.1 Medical approach to recovery

Research suggests that recovery-oriented treatment is in its infancy (National Treatment Agency for Substance Misuse 2011). Nevertheless, the U.K. model of care has put recovery at the heart of treatment.

The goal of the new drug strategy in the U.K. is outlined as follows: ‘freedom from drug dependence, well-being and citizenship’ (HM Government UK 2010: 18). To achieve this objective, an expert committee was set up by the National Treatment Agency for Substance Misuse (N.T.A.), to develop a comprehensive framework for recovery-oriented drug treatment. The interim report of the committee includes statements about best practice, improvements that can immediately be made to current practice, the new emphasis on recovery, and identification of key areas that are important for delivering a comprehensive medical framework for recovery. (National Treatment Agency for Substance Misuse 2011). These four aspects are discussed next.

First, the committee states that some key elements of effective drug treatment already exist in clinical and other guidance though are not always followed in practice:

- A comprehensive assessment of need should be an integral part of the therapeutic process. The recovery care plan that develops from this assessment and review should be developed in collaboration with the patient

so that it can be owned by the patient. Furthermore, the care plan should be centred on the patient to ensure individual responses based on need.

- Adoption of regular use of common validated measures should become part of the clinical practice.

- Regular reviews of progress should be conducted to enable clinicians and patients assess needs and appropriate responses. Such repeated reviews should lead to the best treatment for the individual. If a patient derives little benefit from treatment, further treatment should be modified and tailored to suit the individual's need in partnership with the individual.

- The provision of medication should not constitute the totality of treatment. Overall need care must be considered, such as individual recovery care planning, psychosocial interventions and integration with mutual aid and peer support.

Second, the committee proposes some immediate actions to improve recovery-orientation and provide suitable support. These suggest that patients will be supported to achieve recovery in two main ways: through improving recovery objectives (that is, harm minimisation and overcoming drug dependence), and through prescribing and ensuring that there is appropriate support for patients to get most benefit from treatment. Interestingly, the committee also proposes that opportunities should be created for patients to increase social capital through training opportunities and work experience, and that attention should be given to patients'

social networks, by incorporating families (where this is suitable) and by facilitating access to mutual aid groups. It is also suggested that training is provided for key workers and that collaborative interventions should be supported.

Third, the panel identifies that there is a need for renewed emphasis on improving patients' recovery. This is hoped to be achieved by constructing personalised recovery care plans which include support for individuals to re-integrate with main stream society and peer support.

Finally, the panel suggests that key areas are important for delivering a comprehensive medical framework for recovery, including the development of patient placement criteria; determining how progress in treatment can be measured; examining how treatment interventions can be better organised to support a personally-relevant and evolving journey of treatment and recovery.

2.4.2 Psychological approaches

Four different concepts which explain recovery from drug dependence will be explored. These are the idea of 'maturing out', a staged model to recovery, the notion of turning points and the management of identity.

Maturing out of addiction theory

Maturing out of addiction theory was first proposed by Winnick in 1962. He argued that addiction is a self-limiting process for a large proportion of addicts and two-thirds of people outgrow the habit when they reach their mid-thirties. This idea was contrary to the popular belief at this time that addiction was a life-time problem (Prins 1995). Although this theory offers one possibility through which addicts may recover from drug addiction, Prins (1995) points out that it does not clearly show how dependent drug users recover from drug dependency. To test the validity of Winnick's ideas, Prins carried out a study in the Netherlands a few decades later. His research confirmed Winnick's findings, and adds that a drug-dependent person matures out when a person's social identity is built up, and they can then live an independent life without drugs.

The stages model

Recovery has also been described as occurring through a process of stages and researchers have proposed a variety of stages of recovery for substance misuse and dependence. In his review of different models, Klingemann (1994) suggests that Tuchfeld (1981) proffers a four-stage model of recovery progressing from problem recognition, to disengagement, then initial changes in alcohol-related behaviour and finally sustained alcohol-related behavioural change. Sustained change was supposed to be influenced by an individual's ability to commit to a change and in particular, the efficacy of informal social control such as family, friends, and favourable professional and financial conditions. Another study by Stall (1983) corroborates the

idea that support provided by significant others is of great importance during the phases of disengagement and stabilisation in the process of spontaneous remission.

Stall and Biernacki (1986) also offer a staged model for understanding spontaneous remissions from problematic use of substances, this time seeing it in three stages. The first stage involves motivation building, the second, public negotiation of the individual's new and non-stigmatised identity and the third is concerned with stabilising change through abstinence or controlled consumption. The authors suggest that the primary drivers of change are financial factors, health problems coping with sanctions and influence of significant others. Social support is identified as also important in achieving redefinition of identity and access to support in the third stage. They suggest that changes in relationship are significant in initiating and sustaining spontaneous remission.

Prochaska et al. (1992) provide a five-stage model for understanding the stages of recovery from addictive behaviours, in their paper titled 'In Search of How People Change.' This work has become a classic study of behaviour change, used across the world. The authors suggest that drug-dependent persons usually recycle through these five stages before quitting addiction: pre-contemplation, contemplation, preparation, action and maintenance. Pre-contemplation is described as the stage when there is no intention to change behaviour, because at this time, people are not aware they have a problem. In contrast, contemplation is defined as the stage when people in addictive behaviour know that they have a problem and are thinking about

making a change but are not yet committed to it. The next stage is the stage of preparation when there is an intention to change, when they may begin to reduce their drug consumption. The action stage is the stage when addictive behaviour is modified. In the maintenance stage, the gains of the action stage are consolidated and efforts are taken to avoid relapse. These five-stage process of recovery is taken forward by DiClemente (2003) in his book on addiction and change. It is important to note that to achieve change from pre-contemplation to contemplation, DiClemente, places a lot of responsibly for change on the individual. He argues that pre-contemplators are capable of directed and self-regulated actions and thoughts and argues that pre-contemplators can evaluate the consequences of their actions and change. This, he argues, can be achieved when the individual is sober or most distanced from their addictive behaviour. Furthermore, DiClemente proposes that it is essential to strengthen commitment by creating a plan for what is needed by an individual to successfully modify or stop using drugs; having a plan helps an individual to take actions such as avoiding the places and people connected with addictive behaviour, strengthening attempts at alternate coping strategies to deal with cravings, taking steps to modify addictive behaviour and getting involved in other activities not related to behaviour, like involvement with family and school work. He also argues that other issues should be evaluated during the period of preparation. Therefore, he is emphatic that 'taking action to make change' is the most important factor to move from preparation stage into action stage (DiClemente 2003: 165). During the action stage, DiClemente suggests that changes occur when addicted individuals cut away the ties that bind them to addictive behaviour, such as physiological, psychological and social, and start to create new patterns of behaviour.

Commitment and active employment of behavioural change processes such as self-liberation, re-enforcement management, stimulus control and counter conditioning are crucial to achieving change. People in this category are those that were able to modify behaviour within six months. During the maintenance stage, there is a continuation of action taken to modify change to prevent a relapse.

Although this review shows that that is no agreement on the number of stages an individual passes through before recovery, three common stages identified are the pre-action stage, action stage and maintenance stage. Moreover, one common factor important in facilitating change that was expressed by the authors is that external support is needed during the stages of disengagement from drugs and maintenance of recovery.

Turning points

Turning points can be defined as events that bring changes to the lives of individuals (Sidhva 2004). Many studies have shown that turning point experiences are important in recovery (for example, Stimson and Oppenheimer (1982) on heroin addiction, treatment and control in Britain). Biernacki (1986), Prins (1995) and McIntosh and Mckegany (2000) also establish the importance of turning point experiences in recovery. A recent study by Haight et al. (2009) conducted on rural Midwestern women in the United States also supports the idea that turning point is an important factor in recovery. In their study of mothers' recovery from methamphetamine addiction, they found that prison sentences and loss of children to

other carers were significant turning points in encouraging the women to give up drug use.

Management of identity

Biernacki (1986) describes the recovery process in terms of the management of what he calls 'spoiled identity'. From his study of heroin users who recovered naturally, he proposes that heroin-dependent users can recover when they are able to identify the need to restore their identity that has been spoiled and construct a non-drug identity. He suggests that for most opiate-dependent users, the decision to quit using the drugs arises when a person's drug identity affects or conflicts with other people's non-drug identity. Other studies support the view that the construction of a non-drug identity is important to recovery. For example, McIntosh and McKegany (2000) suggest that an important part of this process is the capacity of the individual to maintain a narrative of his biography. Their research focused on drug uses at different stages: those who claimed they had stopped using drugs, those who said they had limited their drug use to cannabis, and those on methadone treatment. In constructing a 'non-addict identity', people needed to reinterpret aspects of their drug-using lifestyle; reconstruct their sense of self; and provide explanations that were convincing to themselves and others for their recovery. The study revealed that at the later stages in dependent-use, drug taking was seen in a negative way; it was no longer pleasurable and they now viewed their relationship with other drug users as distasteful and lacking genuine friendship. Informants also said that they had taken drugs to prevent unpleasant withdrawal symptoms and to enable them function. Therefore, the authors

suggest that by reinterpreting elements of their drug-using lifestyle, they were able to distance themselves from illegal drugs and their use; such distance was necessary in the process of construction of a 'non-drug addict' since it had no relevance to their sense of self. In addition, informants made a distinction between themselves before using drugs, and the person they had become because of using drugs. By creating this distinction, they were able to provide proof of their new status. In this way, the past could be rejected and the future re-designed to show a true expression of their real self. The researchers suggest that being able to provide reasons for stopping drugs was important to identity formulation. Reasons included the prospect of a custodial sentence, the death of a partner and also positive turning point experiences such as finding a partner and the birth of a child (see above). The role of significant others was also identified as important in the construction of narratives of recovery.

Other studies which support the importance of identity in recovery include Millar and Stermac (2000) and Grant (2007). The study by Millar and Stermac (2000) explored the process of recovery of women who have the dual issues of adulthood substance abuse and childhood maltreatment. They found that recovery was achieved in three ways: re-shaping the concept of self, managing emotions, and developing a new sense of identity. The study by Grant (2007) examined rural women's experiences of recovery from dependent drug use through a qualitative study of 25 former drug-dependent persons with an average of eight years post-recovery experience. The findings suggest that through new definitions of self, the research participants discovered real alternatives which could provide direction for their lives during the period of recovery.

2.4.3 Socio-environmental approaches

A review of studies on environmental aspects of recovery by Klingemann (1994) demonstrates that environmental factors play an important role in the process of recovery in spontaneous remissions from dependent drug use. They identify three key findings here: social support, influence of informal support systems and geographical or situational change. Kendell and Staton's early study (1966) suggested that social stability of the workplace, the family, and development of satisfying personal relationships were determinants in recovery. In addition, Saunders and Kershaw (1979) showed that the mechanism behind the change experienced by ex-problem drinkers was the establishment of new, or improved significant relationships and severance from alcohol-related employment and other changes in life circumstances. Klingemann (1991) supports this view, suggesting that motivation to change is largely determined by positive changes in personal relationships. Other studies by Tuchfield (1981), Stall (1983), and Stall and Biernacki (1986) reveal the importance of significant others such as family and friends in recovery, in the action and maintenance stage of recovery. Waldorf and Biernacki (1981) and Waldorf (1983) point to the influence alternative-religious and ideological groups in identity transformation. In a different study, Robins (1978) in his study of outcomes of soldiers who served in Vietnam reveal that upon return, dependence on heroin was rare and re-addiction was low.

In addition to this review by Klingemann, Blomqvist (2002) shows the role of environmental factors in treated and self-remissions. He proposes that environmental

factors play a vital role both in spontaneous and assisted recovery. His findings reveal that stable cessation was preceded by prolonged high levels of stressful negative events in both types of recovery. Self-remissions were caused by positive factors such as situational change while treated remissions were brought about by negative factors such as 'rock bottom' experiences (2002: 143). Support from significant others, changes in living circumstances and social life changes were all found to be significant for recovery in the maintenance stage.

2.4.4 Spiritual approaches

This section discusses a popular model of recovery, the A.A. model, with a view to providing an understanding of spirituality and recovery from drug dependency.

The A.A. 12-step model of recovery

The A.A. advances the 12-step model of recovery and recommends that recovery is achieved by going through the 12 steps. This model, have also been adopted by some mutual-help groups for other types of drug dependency, as discussed in section 2.3.4 The basic 12-step principles of recovery are:

> '1. We admitted we were powerless over alcohol- that our lives had become unmanageable.
>
> 2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly ask Him to remove all our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all or affairs.'(Alcoholics Anonymous 2007)

The A. A. 12-step principle is explained in the '*Alcoholics Anonymous Big Book'* (2007). The first principle is based on the ideas that the root of alcoholism is self-centredness; alcoholics have no control over drinking and admission of powerlessness is a first step in resolving the problem. The second step is founded on the belief that only a higher power greater than the alcoholic could restore such a person, through unconditional surrender of selves to God as each person understands Him. The surrender of self is understood as putting God in charge of a person's life. This third is regarded as the foundation for a new and triumphant path to freedom from alcoholism, provided individuals kept close to God, being all-powerful, He met their needs and they became less self-centred and increasingly made contributions life. As individuals experienced God's power, and peace of mind, they realized that they could face life more successfully. In addition, as they became conscious of His presence, fear was removed. Consequently, by forming a relationship with the living creator, a new life was received; old ideas, emotions and attitudes make way for a new set of ideas and motives. This experience is regarded as 'a new design that really works' (Alcoholics Anonymous 2007: 25). The fourth involves taking an inventory of self to enable individuals identify their flaws and address them. Step five, is the process of confession of personal defects to God and to other human beings. This is needed in order to get rid of the double life associated with alcoholism, need to stay sober and to maintain a close relationship with God and grow spiritually. Steps six to 11 requires making amends by asking God to remove the defects, making necessary amends with those that have been hurt, continuously making personal inventory of self and spiritual growth through improving conscious contact with God by prayer

and meditation. Having experienced a spiritual awakening, step 12 involves practical involvement to help other alcoholics.

Evaluation studies indicate that the A.A. 12-step model of recovery is effective. Peteet (1993) suggests that the contributions of the A.A. 12 steps to recovery from chemical substances are: providing accessible group support and a clear ideology of addiction and addressing individual's need such as identity, integrity, and interdependence. Khantzian and Mack (1994) also affirm that the 12-step model is an important resource in recovery. They suggest that the group psychology accesses and corrects core problems with self-regulation such as self-governance, affects and self-care. These two studies confirm the importance of group support in recovery. In addition, it reveals that recovery is achieved through story telling in which members are able to share and witness each other's vulnerabilities and drug using experiences. Khantzian and Mack suggest that this process enables individuals to realize that their problem is not unique to them and that they need the support of others to obtain and maintain sobriety and to understand their own problem and others**.** Furthermore, the findings suggest that first step in recovery is to accept one's vulnerability as being powerless over alcohol dependence. Moreover, the group process helps to reinforce the decision to remain abstinent on a daily basis, help self and others to take active responsibility for their own recovery. However, both studies show that the A.A. method is only beneficial to those who are willing to accept the concept of a higher power and the concept of powerlessness over drug dependence.

Another study, Green et al. (1998) claim that surrender to a higher power results in life altering transformations, which leads to an intense spiritual journey that enabled sustained abstinence. The finding agrees with the claims in A.A. (2007) in the *Big Book* which suggest that the most fundamental influence on recovery of members is surrender to a higher power. Their experience is expressed in the quote below:

> 'In the face of collapse and despair, in the face of the total failure of their own resources, they found a new power, peace, happiness and a sense of direction flowed into them' (Alcoholics Anonymous 2007: 35)

Furthermore, in an exploration of spirituality among African American Women recovering from substance abuse, Wright (2003) also argues that surrender to a Higher Power, is the beginning of a spiritual journey toward spiritual and ultimately recovery from substance abuse. In the study, she ascribes the concept of a Higher Power was ascribed to God or Jesus Christ in the study. Further, she suggests that sincere repentance, purging the self and confession produced genuine surrender. A.A. suggests that recovery is achieved through going through the 12 steps.

2.4.5 Integrative approach

Whole Person Recovery

Daddow and Broome (2010) propose a user-centred systems approach to problem drug use, referred to as the whole person recovery system. The whole person recovery system views different aspects of the recovery process as subsystems which interact and sustain each other and also make up a system for whole person recovery. There are four key aspects to this approach. First, for a person to achieve recovery,

the model suggests that there are a set of activities (referred to as sub-systems) which need to be undertaken. For instance, the proponents suggest that activities such as resolving to stop drug dependence, prioritising engaging in the recovery process, recognising existing recovery resources, engaging in recovery actions, acquiring and building recovery capital, could result in increasing participation in the society. They also propose that series of activities could be tailored to the individual and local community. They also believe that for the outcomes of each sub-system to be effectual, they need to be supported by social networks or the wider community. Second, the authors said that there is less chance of recovery if any activity (sub-system is missing or weak). Third, there is a main sequence of activities which are likely to reinforce each other. Fourth, recovery is facilitated and sometimes only possible with suitable support and enabling conditions.

Recovery capital model

The construct of recovery capital was introduced by Cloud and Granfield (2008). They propose that recovery capital is the sum total of resources a person possesses which can be drawn on for initiation and maintenance of recovery from substance misuse. These resources include social capital, cultural capital, physical capital and human capital. They suggest that social capital is the resources that are available to an individual from social networks of mutual interest. The importance of social networks has been advanced by Putnam (2000) who defines social capital as 'social networks and the norms of reciprocity and trustworthiness that arise from them' (2000: 19) Cultural capital was defined as cultural norms such as values, beliefs, dispositions, perceptions and appreciations derived from membership in a particular

group. Physical capital was referred to as financial or economic capital such as investment, property, savings, income and tangible financial assets. Human capital was viewed as the individual attributes (such as knowledge, skills, educational qualifications and health) that enable a person function in society. Cloud and Granfield (2008) argue that recovery can be positively affected by the types and amount of recovery that a person has access to.

This model has been taken forward by Best and Laudet (2010) They emphasise the significance of social capital, especially community engagement, such as recovery groups, as a vital resource for recovery from dependent drug use. These groups, referred to as 'ready-made' social support, provide role modelling and significant support, for resolving problems well beyond substance related issues (2010: 5).

2.4.6 Summary of recovery approaches

This review explored contributions from medical, psychological, socio-environmental, spiritual and integrative perspectives. It shows that identified routes to recovery are through pharmacological prescriptions in combination with other effective interventions such as psychological treatment interventions and acquisition of social capital, maturing out of addiction, management of the spoiled identity, turning points, support from significant persons, situational change, and surrender to a greater power. Moreover the integrative perspective argues that activities that support recovery need to be undertaken and tailored to the individual's need to ensure recovery is achieved.

2.5 Summary of theory and key research findings

The review was divided into three sections: perspectives of drug dependency, treatment and recovery approaches. Regarding the nature of drug dependency, the review showed that drug dependency has been understood in different ways; medical science views it as a disease; psychological focusses on intra and inter-personal factors; socio-environmental perspectives consider environmental factors such as family, peers and environment; and the spiritual perspectives suggest that drug dependency is related to spiritual deficiency. Each of the perspective provides specific contexts within which drug dependency, treatment and recovery can be explored. Since spirituality is an important aspect of people's lives in the study context, spiritual dimensions of dependency is considered as important to the present study.

Furthermore, the review showed that treatment approaches are diverse and each type is founded on specific theoretical orientations; medical, psychological, socio-environment and spiritual. Effectiveness studies revealed that each treatment approach contributes in different ways to recovery. Medical approaches are effective in harm reduction, psychological approaches in relapse prevention when combined with substitution therapies and socio-environmental and spiritual approaches are effective for achieving and maintaining sobriety. In the study context, one effectiveness study of treatment facilities in year 2000 was located by the researcher at the time of study. This suggests that there is need for more studies in this

geographical region. Socio environmental and spiritual perspectives are of particular importance to this study is important to the study because of their cultural relevance.

On recovery, literature reveals that there are various routes to recovery. Moreover, one of the integrative approaches proposes a user-centred recovery which embraces activities that enable recover. In addition, the recovery capital model focuses on the benefits of recovery capital. This study seeks to explore the major contributions to recovery, and in particular, the Pentecostal Christian faith-based approach, due to the importance attached to spirituality in the study context and popularity of faith-based approach to treatment.

Chapter 3 - Methodology

3.1 Introduction

This chapter focuses on methodology, beginning with the design and rationale for the study, before going on to discuss in detail the methods chosen as well as ethical and practical issues arising from the study. Data analysis is also explored, as are the advantages and limitations in this study.

3.2 Design and rationale

This study will be approached within a constructivist approach which posits that social phenomena and their meanings are socially constructed continually; that social order is in constant state of change because is it produced through social interaction (Bryman 2008). This approach is employed for the following reasons: first, it focuses on how social order is created through talk and interaction (Elliott 2005); and second, it is useful for generating data from exploratory questions (Bryman 2008).

I adopted a qualitative research design using a case study approach, enabling me to focus in depth on the phenomena of drug dependence and recovery in one study context. The case in this study centred on the Wellspring Rehabilitation Centre (W.R.C.) in Lagos, Nigeria. The primary method of data collection was qualitative interviews with service users and their families, and semi-structured interviews with staff. I also employed two other methods to supplement the data from qualitative

interviews: participant observation, which gave me first-hand access to the day-to-day practices of the centre and the experiences of informants who were undergoing treatment as well as those who had achieved sustained sobriety; and documentary research.

Defining qualitative research, Snape and Spencer (2003) suggest that there is broad agreement that qualitative research is a naturalistic, interpretative approach that focuses on understanding meanings which individuals attach to phenomena such as actions, decisions, beliefs, and values within their social world. Looking at this more in more detail, Bryman (2008) defines qualitative research as a research strategy that focuses on words instead of quantification in the data collection and analysis. He adds that it is an inductive approach to theory, and has a flexible approach to constructing social reality.

I adopted a qualitative approach for several reasons. First, I found this design suitable because, as Robson (2002) submits, a qualitative approach is well-suited to explorative research like this study which is aimed at understanding the process of recovery from drug dependence. Second, a qualitative design fitted my research questions, allowing explanations on the processes of recovery to emerge from the data. Third, the approach enabled me to explore the meanings that informants attached to their experiences. Fourth, the design allowed me to use different methods of data collection, including in-depth and semi-structured interviews and observation. Finally, the flexibility which comes with a qualitative approach allowed me to adapt

to field conditions as I learned from the data. I will now discuss particular aspects of the design in more depth.

The case study approach

Stake defines the case study approach as the study of 'the particularity and complexity of a single case, coming to understand its activity within important circumstances.' (Stake 1995: xi). Case studies may also add to our knowledge of individual, group, organisational, social, political and related phenomena (Yin 2009). Yin proposes a two-fold definition of case studies, which he outlines as an in-depth investigation of a contemporary phenomenon within its 'real-life' context and also as a method which relies on multiple sources of evidence (2009: 18).

I adopted a case study approach in order to explore the phenomenon of recovery from the perspectives of a particular group of people (that is, those involved with the Wellspring Rehabilitation Centre) and a particular kind of treatment (that is, a Christian faith-based intervention). This entailed finding out about recovery experiences from interviews with service users, with their families and with staff of the agency. It also involved using different sources of evidence such as interviews and observation. It was hoped that through conducting the research, the findings might facilitate the improvement of services in the agency. Since the researcher is also an employee of the centre (on study leave), the project holds special importance. Everitt et al (1992) argue that for a practitioner, it is usually the case that there is a desire for research to bring practical value to the agency being studied. It is hoped

research will lead to greater understanding of practice, incorporate findings into delivery of services, make informed choices, keep to date with advancement and put aside redundant theories. These were all important considerations for me in undertaking this study.

Some research literature has been critical of case studies, suggesting that the findings of case studies cannot be generalised. Nevertheless, Punch (1998) argues that generalisation should not necessarily be the aim of a research project and suggests that the case study method is an effective method for developing concepts, based on the grounded theory or a new research area. Stake (1995) similarly emphasises that the business of case study is to have an understanding of the case. In addition, Yin (2009) similarly argues that although case studies may not be generalisable to other populations, generalisations can be made from case studies to theoretical propositions. Since the main aim of the study is to contribute to the understanding of the concept of recovery from dependent drug use, and contribute towards improving the services of the agency from which the case was selected, I believe that using a case a case study is appropriate for this study. Not only this, recovery from drug dependence is a topical issue and it is widely acknowledged that the processes of recovery need more investigation. For example, McIntosh and McKeganey (2000) claim that:

> '….the process through which such recovery comes about remains far from clear. We know relatively little, for example, about the contribution of treatment interventions in facilitating such recovery; what works, for

whom and under what circumstances are questions that are a long way from being resolved.' (McIntosh and McKeganey 2000: 1501) .

Here lies the challenge for this study; to find out more about recovery in one particular context, and from this, to learn more about recovery in general.

3.3 Research Methods

I adopted qualitative interviews as the primary of data collection as follows: in-depth interviews with service users, in order to explore the experiences of individuals and the meanings they attached to their experiences, and with family members, in order to find out about their contributions to the recovery process; and semi-structured interviews were used with members of staff of W.R.C, to gain more understanding of their interventions and role in the recovery process. I also conducted participant observation and documentary research. These methods are discussed in detail below.

I also prepared myself to do the fieldwork by taking training in data collection, interviewing and reflexivity at The University of Edinburgh.

3.3.1 Qualitative Interviews

Rubin and Rubin (1995) suggest that qualitative interviewing is a method of learning about people's feelings, thoughts and experiences. This is achievable through

conversations guided by the researcher, who introduces a limited number of questions and asks the informants to explore these questions in depth, and to reflect in detail on events they have experienced. Further, understanding can be achieved when research informants are encouraged to describe their own worlds in their own terms. Rubin and Rubin suggest that interviewing involves a relationship between the interviewer and the informant, one which demands obligations from both persons. Legard et al. (2003) state that the role of the interviewer is to facilitate the interviews in a way that the informants are able to express their thoughts, feelings, view and experiences without influencing the views being articulated. This requires managing the interview process to achieve depth, steering the discussion to the topics of discussion and making good judgements about length of time of interviews and what questions need to be asked, how they should be framed and what answers need to be followed up. They also indicate that the role of the informants in the interview process is to give detailed answers and provide more depth when follow up questions are asked. Significantly, Legard et al., assert that qualitative researchers are themselves research instruments, in contrast to quantitative researchers who seek to distance themselves from the research process.

Many authors have advanced the usefulness of qualitative interviews. Robson (2002) states that qualitative interviews are most appropriate for studies such as the one being carried out which focuses on finding out meaning individuals bring to their experiences and for explorative work. In addition, Robson claims that a qualitative interview method is flexible, enabling interview questions to be adapted to field conditions, unlike structured questionnaires. This means that unplanned, important

issues which arise from an interview can be investigated. Mason (2002) suggests that qualitative interviews allow a researcher to be reflexive and allow ethical and political issues to be taken into account in the research process. Lee (1993) adds that qualitative interviews are better tools for generating information on sensitive topics because it is possible to probe deeper and thus generate more valid data.

In-depth interviewing is one commonly-used approach to qualitative interviews. Legard et al. (2003) suggest there are some key features which are common to in-depth interviewing. First, in-depth interviewing allows flexibility in the use of topics/themes. Second, data is generated through interaction between the interviewer and the informant. Third, the interviewer may use several techniques to obtain depth regarding explanation and exploration. Fourth, initial answers are followed up by questions, so as to have a fuller and deeper understanding of participants' meanings. Finally, in-depth interviewing allows an exploration of all factors that account for the informants' answers, such as reasons, feelings, opinions and beliefs. In order to seek meaning from the language of informants, interviews are usually captured in their natural form, by the use of a tape or digital recorders. Legard et al. (2003) state that the role of the researcher in in-depth interviews is to listen; to have a clear mind in order to be able to make good judgements and formulate relevant questions; to establish rapport with informants; to ask relevant questions; and to prepare well in planning and delivery of the interview.

In contrast, semi-structured interviews use pre-determined questions. However, this does not suggest that there is no room for flexibility. On the contrary, Robson (2002) argues that interview questions can be adapted to field conditions; words can be changed, and questions omitted if thought to be inappropriate with a particular informant. Additional questions arising from the interview can also be investigated. This method was chosen for use with members of staff in the agency to allow for some standardisation, but also room for individuality of responses.

Conducting qualitative interviews in the study

I am pleased to record that there was good and timely response to interview appointments by most service users and parents. The only exceptions were two former service users who did not turn up for interviews, and one male service user who declined to take part.

I started each interview in what I hoped was a warm and friendly way so that informants might feel as relaxed and comfortable as possible. This was facilitated by beginning each interview with an exchange of pleasantries and by using venues that were conducive for the interviews and not having third parties around. I then went on to explain the nature, purpose, and importance of the research to the informants. I also explained why they had been selected for interview and the purpose of the interview. Informants were asked to read the consent form and in some cases where they could not read English, this was read to them. I asked for their consent to participate by signing the consent form. I also sought their consent for the use of

recording equipment. Confidentiality was assured by letting them know that their identities would not be revealed in the study. (Issues of confidentiality in the study are discussed in section 3.4.3.) I also explained how the interview would be conducted, such as responding freely to questions, being honest about their experiences, providing detailed answers and the freedom not to continue with the interview if they wished to stop at any time.

The in depth interviews

During the in depth interviews, informants were asked to share their experiences along pre-scheduled interview guides or themes of interest (see Appendix 2, guides 1-4). These helped to keep me on track and ensured that all the themes and concepts that I was interested in were explored. The interview guides also helped the informants to reconstruct the specific aspects of their experiences that related to drug dependency and recovery, providing them with a narrative structure and a temporal ordering of their accounts. Aspects of the interview which needed clarity were asked as follow-up questions. I also used silences to enable the informants to reflect and expand on issues that were explored.

I knew that it was important to encourage informants to take an active role in the interviews, and that I should be sensitive to the emotions and sensitivities of the informants. Each informant was therefore allowed to take time to share their experiences. I sought to show interest in the discussion throughout, empathising when difficult experiences were shared and listening and encouraging informants to

talk, using both verbal and non-verbal communication. Furthermore, questions were always explained in order to make it clear what was being asked. I was also patient, recognising that each person is different. For example, the last interview was held with a service user who had been re-admitted into treatment with a new set of service users, following a relapse. When I first asked to interview him, he requested a rescheduling of the interview, and I agreed to this, given his unsettled and anxious presentation. I reminded him of the purpose of the research, and he subsequently gave a very useful interview. There was also an instance when an interview caused emotional stress when one informant talked about the break-up of his relationship with his wife and children when he was drug-dependent. I showed concern for him and gave him time to recover and continue when he was ready.

It is important to acknowledge the inevitable imbalance of power relations in the interview process. I sought to minimise this by having a non-condemnatory attitude, having proper regard for the informant and by being open to what was important to the informants (Bryman 2008). I also sought to build rapport with the informants, letting them 'tell their own stories' (Reissman 2008). (Issues relating to power is further discussed below under the subheading; 'negotiating boundaries in the research process')

The semi-structured interviews

Semi-structured interviews were conducted with members of staff of the agency with the use of a questionnaire format. Separate questions were used for the two groups as

shown in Appendix 2, guide 5. Issues were explored by use of probes and prompts. Probes are responsive questions, which were asked to elicit more information from the informants. To facilitate rapport and encourage the research informants to take an active role in the interview, I sought to be an active listener, being sensitive to the tone and body language, and allowing the informants' time to respond. It is important to note that it required little effort to gain rapport with the members of staff of the agency, in part because they all knew me already.

Closing the interviews

Before the close of each interview, I expressed appreciation for the time and contribution to the research. Informants, in particular service users and family members, were asked if they had any additional information they wanted to share. A few responded by giving advice or sharing personal concerns, and this was also recorded. Most people thanked me for the opportunity to share their experiences. Further, I asked informants if I could call on them if this was found to be necessary to fix another interview and the response was positive. The interviews ended with exchange of pleasantries from both me and the informants.

Location and Criteria

The fieldwork was carried out in Lagos, Nigeria between June and September 2009, in W.R.C, a treatment centre that provides care for drug-dependent users. The choice of this location was based on the motivation for study, which came from the experience of caring for dependent drug users, in an agency in Lagos, Nigeria and the desire to provide better care for the service users.

The study group

Interviews were conducted with three groups of people:

- Service users in treatment and former service users
- Relatives of service users
- Agency staff

The primary group being studied were the service users who had first-hand experience of drug dependency and recovery. The other two groups were studied to provide additional information. The sampling strategy employed for data collection was purposive sampling. Silverman (2005) notes that purposive sampling allows the researcher to choose from the population a case, based on some features or process they are interested in. This approach enabled me to study people who had experienced drug dependency and recovery and had accessed treatment in a particular organisation.

Fifty-three interviews were conducted in total: 41 interviews were held with service users in treatment and former service users; six interviews with family members; and seven interviews with members of staff. Only 38 interviews with service users were used for the purposes of analysis as will be described further below and shown in figure 3.1.

Of the 41 interviews with service users (present and past), this group was made up of three sub-groups: persons in sustained sobriety; persons in treatment; and persons unsuccessful after treatment. The sustained sobriety group consisted of former service users who had completed the treatment programme and claimed they are no longer using drugs. Their post-recovery experience ranged from two to five years. This stage is often classified in the literature as a 'sustained recovery' group (Betty Ford Institute 2007) This group was selected because they provided evidence about recovery and how this was achieved and maintained. I had originally planned to interview six persons in this category, but in the end, 14 were interviewed because I became interested to find out how different factors worked for different people. The group in treatment was made up of service users from the two phases of treatment: the recovery programme (the first phase of treatment) and the vocational programme (the second phase of treatment). The first group in treatment were able to reflect on how recovery was being achieved during treatment and the difficulties being experienced. At the time of fieldwork, they were completing the five months in treatment. Service users interviewed in the second phase had been in vocational training for between one and two years. Fifteen service users in treatment were interviewed, but only 13 were subsequently analysed: seven in the first phase of

treatment and six from the second phase of treatment. Two interviews were not used because one person had relapsed and another had stopped using drugs before enrolment; this was discovered during the interviews, after selections had been made. The unsuccessful group consisted of two categories of service users who were unsuccessful in resolving dependent drug use. The first category included those who had dropped off the treatment programme. This allowed me to explore the personal, interpersonal and other factors and conditions that make people drop off the treatment programme. The second category consisted of those who had relapsed either after completing the first phase or second phase of treatment. This sample was selected to explore factors and conditions that make treatment retention ineffective. The number of interviews conducted with persons who had dropped off treatment was six, however only five interviews were analysed because one person dropped off. In addition, six people who had relapsed were interviewed.

Figure 3.1 Service users in the study

Service users	**Sub-group 1**	**Sub-group 2**	**Number used for analysis**
Achieved sustained sobriety			14
In treatment	7	6	13
Unsuccessful after treatment	5	6	11
Total			38

Access to the agency and to informants

Permission to conduct the research in the W.R.C. was sought from the head and granted about 10 months before fieldwork commenced. Access was granted readily because one of the main reasons for which the study was carried out was to improve the services of the agency. Further, my role as a member of the management team of the agency also facilitated access.

Recruitment to the study

Research participants were recruited in three ways: through the agency where the research informants were drawn from, through direct recruitment by the researcher, and through the assistance of two research assistants. In the first instance, the agency provided me with the names of possible informants and introduced them to me. The rationale was to select two groups of people: first, persons who were in the first two phases of treatment at W.R.C.; and second, persons who had accessed treatment at the W.R.C. who either did not complete treatment or relapsed. Direct recruitment by the researcher involved calling up potential informants personally through telephone calls and at other times, speaking to them face-to-face. All family members and staff of the agency were recruited in this way as well interviews with all staff members. The approach followed what has been called 'snowball sampling', where leads are followed up and the study sample grows accordingly. This approach was successfully used by Biernacki (1986) to recruit research subjects for a study on pathways from heroin addiction. I also engaged two research assistants from the recovered group who assisted me in contacting others who had previously enrolled for treatment at the W.R.C. My helpers knew where and how to locate them, and there were no issues about confidentiality because the service users already had contact with one other outside the agency. However, it was difficult to recruit those who had been unsuccessful following treatment (and were still dependent on drugs) because my research assistants were careful not to enter the places where drugs were being sold where we might have been able to recruit them. Unfortunately, those that were contacted demanded for money to buy drugs before consenting to be interviewed, with the exception of one person. Since it is against the policy of the

agency to give money, these persons could not be interviewed. Fortunately, some persons in the unsuccessful group had re-enrolled for treatment.

Venue of interviews

I intended that all interviews would be carried out in the facilities of the agency being researched. This decision was taken to ensure physical safety and privacy for the researcher and everyone involved in the interviews. It also provided a comfortable atmosphere for the interview, which enabled the researcher and the research informants to be relaxed, encouraged openness and prevented intrusions during the interview process. The decision was also taken to avoid going to the 'joints' to interview persons who did not succeed with treatment and were still in drug dependency at the time of study. Drug joints in the context of study are places where drugs are sold and consumed. I felt that these would not be safe places to conduct research interviews because of the potential risks to the researcher. Consequently, interviews were conducted in the offices of the W.R.C. at Ojodu and Ikeja, where most of the interviews were conducted, an office in the House of Joy, Surulere and in two homes, one of a family member and the other of a senior member of staff of the W.R.C.

Negotiating boundaries in the research process

I am an employee of W.R.C. (Project Executive Secretary), currently on study leave. My primary job functions include design of the programmes of treatment of the agency; coordination of the activities of the operating arms of the agency (training, administration/finance, and drug education), staff recruitment and development, budget planning and implementation. In addition, I was involved in lecturing and counselling. I was also the editor of the agency's newsletter, and directly supervised the vocational training programme and job placements of graduating service users. Furthermore, I am married to the project coordinator.

Being an employee of the agency positions the researcher as an insider researcher. The insider researcher is one with a professional responsibility to ensure that services that clients receive are effective, through carrying out empirical studies (Rubin and Babbie 1989). However, there has been increasing debate about the validity of insider researcher studies. Innes (2009) notes that it is suggested that the closeness of insiders to their research may distort their views and result in biased research findings. The question this raises for the insider researcher is, 'how can research be conducted without compromising the quality of the research?' Considering my position as an insider researcher, I reflected on this deeply. I did not see any conflict between my roles as researcher and employee because I had the support of the agency to conduct the research which it was hoped would contribute to the effectiveness of treatment practices and outcomes. In this sense, I felt that my researcher and employee obligations were in tune with one another, and in tune with

the idea that I needed to be fair and open in disseminating research results, as outlined by the Social Research Association .(2003) As a researcher, I was aware of my responsibility to generate knowledge that would meet scientific standards in methods of data collection, analysis and dissemination of findings; moreover, I had to carry out a research project that would contribute to knowledge and practice at the same time as being sensitive to ethical considerations. In order to achieve these standards, I employed a research design which allowed me to focus on the experiences of the informants, and the meanings they attached to these experiences (see section 3.2). Furthermore, I maintained a critical distance throughout the research process.

Having considered these issues, I recognise that there are other issues which may impact on the interview process and outcomes resulting from my status as an insider researcher. Some of these are the interview situation, the Christian beliefs of the agency and power relations. These issues and the ways they were negotiated are examined more closely in the following paragraphs.

Shulamit (1997) explains that in every research encounter, researchers bring a variety of 'selves' to the interaction; in my case, this included being a professional, being a Christian woman and being an academic/student researcher. Just as I brought these selves to the research, so the research participants also brought their selves as service users, as men or women, and as Christians. This had an inevitable effect on the research, but I was also able to put in place some mechanisms to ensure that my

research findings were as objective as possible under these circumstances. So, for example, I needed to re-establish a research relationship with the informants which was different from my previous relationship with them; I also needed to reassure them that they were under no obligation to take part in my study. In order to do this, I discussed with the informants the purpose and benefits of the research, their role as service users and the need for them to feel able to say whatever they wanted if they were to participate in the study. Knowing that by participating they were making a contribution that might affect the lives of potential service users, they connected with me and said that they felt very good to be a part of the study (Refer to section 3.3.1 on in depth interviews). In addition they were guaranteed confidentiality. I assured them that what we discussed would not be disclosed to other members of the agency. This was managed during the interviews by conducting the interviews in offices and not in open places. Also, I made use of pseudonyms in transcriptions and citations in the thesis. By discussing these issues before the interviews, I presented myself as a researcher and was able to establish a research relationship with the informants. This encouraged rapport and helped them to be relaxed and open.

I also recognise that my beliefs and those held by the agency may have influenced the findings. This was, from the outset, a study which set out to explore a Christian project with a very particular worldview. The questions that were asked, and the answers that were given, were, in a sense, framed by this reality. But again, this does not make the end-results any less useful or interesting than a study of an agency with a different worldview. Etherington (2007) suggests that reflexivity is a resource which assists practitioners and researchers to notice their responses to others and

direct their actions, communications, and understanding from the knowledge gained. I constantly reflected on my questions and sought to ensure that the questions were not 'leading' in any way, and in this way, I tried always to be self-critical of the whole process of knowledge acquisition. Being reflexive helped me to listen and pay attention to what informants were saying. In addition, asking open questions allowed informants to tell me what was important to them. Silverman (2010) emphasises the importance of asking open questions, as a way of getting access to information on issues that were not previously thought of. He also warns against asking direct questions which might affect the responses of informants because they are likely to become aware of the researcher's interests. Of course, the service users whom I interviewed knew that I wanted to hear their stories of recovery, and that I was also interested to learn about the role of religion and spirituality within this. But beyond that, I believe that my agenda was not fixed; informants did tell me stories that surprised me; and the research itself is a reliable indicator of a range of outcomes in a faith-based residential community.

I also believe, reflecting on this further, that sharing similar beliefs with the informants had a positive influence on the research process. Mauthner and Doucet (2003) emphasise the importance of locating oneself in the research process. This means that it is important that researchers are sensitive to issues such as cultural differences, beliefs and cultural context. Talking about faith and religion is not easy, but sharing the same faith with the informants facilitated the interview process, allowing informants to talk about issues regarding their faith freely and with little or no difficulty. Being able to locate myself culturally and spiritually helped me to

understand informants' experiences, the spiritual and cultural values in the study context. It also helped me in the broader analysis of the subject.

Furthermore, I was also cognisant that issues of power may influence the responses of informants in this research. I was acutely aware that my position as a leader in the organization may affect individuals' willingness to be open to me with their experiences, particularly regarding drug use. I therefore sought to keep the principles of informed consent to the fore and not coerce anyone into participation throughout the interview process. I also needed to put people at ease during the interviews. Therefore, I discussed with them issues relating to power, acknowledging their power in the interview relationship as well as my own, letting them know that they were my teachers in this situation. I worked hard to put them at their ease, and endeavored to listen to their stories patiently (refer to section 3.3.1 on in depth interviews). In the end, many of the informants said they were glad to be asked to participate in the study and expressed their appreciation for being asked to take part; knowing most of the informants, particularly the service users, also facilitated the interview process in many ways, big and small.

3.3.2 Participant observation

Participant observation is one of the observational methods in qualitative research (Bryman 2008; Robson 2011). Observation as a method in the social science involves active witness of phenomena under study (Adler and Adler 1994). According to Robson (2011), the advantage of observation is that it involves

watching what people do, and listening to them without having to ask people about their views. Therefore, data can be used to complement information from other methods. Furthermore, he explains that observational methods can either be formal or informal, and the role of researchers participatory or non-participatory (that is, detached observer). Formal observations are usually structured and informal less structured and allows the researcher flexibility in how information is gathered and recorded. I employed participant observation, using a less structured format.

Research suggests that one major feature of participant observation is that the observer, who is the research instrument, becomes a member of the observed group and learn the group's way of life, meanings attached to their experiences and social structure which binds them together (Punch 1998; Emerson, Fretz et al. 2001; Bryman 2008; Robson 2011). This suggests that participant observation can occur for an extended period of time. However, Robson argues that this can also be conducted in a short period of time rather than years. He explains that this might be used with small groups and for activities that can be complemented by other methods such as interviews and informal group discussions. Robson also indicates that participant observers may choose to conceal or reveal their identity as a researcher (Robson 2011).

This method was chosen for this study to complement the data generated by qualitative interviews. I had intended carrying out observation to study the group counselling sessions with service users in- treatment, in order to find out how

service users recovered and to observe the physical changes in their appearance. However, due to unforeseen delays before the commencement of field studies, the group counselling sessions had been completed and observation could not be carried out. I instead observed the new intakes during the first week of admission, to corroborate my understanding from interviews. Loftland (1995) suggests that participant observation always involves a combination of looking and listening, and watching and asking.

Conducting participant observation

In my study, I conducted participant observation by spending significant amount of time in the first week, observing what was going on. I observed the process of admission and deliverance prayers. I also observed aspects of the physical appearance such as body image/ appearance. I also observed their conditions as they withdrew from drugs and their behaviours.

I also interacted with members of staff on informal basis. This means that I gained a lot of first-hand direct experience of the Centre, its life, and the people that worked in it and live there. For example, I observed the structured routines in the centre (refer to appendix 3), the daily activities the interactions between staff and the people. These observations contributed to my study in many ways although I do not have a strict set of data. Rather, these observations, infuses the interviews, findings and analysis.

3.3.3 Documents

Scott (1990: 12) refers to a documents as 'a written text.' Prior (2003) suggests that contents of contemporary documents are varied; they contain words, pictures, emblems, diagrams and sounds in electronic documents. She also said that objects other than words should be regarded as documents; noting that people think with things as well as words. Therefore, she argues that analysis of documents should not be limited to texts. Examples of documents are: personal documents such as curriculum vitae, autobiographies, diaries and documents; public records like media publications, pamphlets, novels, posters and memorials; organizational or administrative records including client records and annual reports; legal and political records such as government and parliamentary papers (Scott 1990; Macdonald 2001; Graduate School of Social and Political Studies 2008).

Documents relevant to this research are administrative records. Hakim (1993) defines these as records that contain information central to the functions of organizations. She also suggests that these records are usually large, spanning a long period, and narrow in content and scope. I gathered bio-data of informants from the agency records to obtain information such as: age, sex, background, years in dependency, and types of drugs consumed. This allowed me to make connections with what the informants were saying about their background and experiences. These data were collected to supplement data from interviews and enrich analysis. Research suggests that documents must meet four criteria: authenticity, credibility, representativeness and meaning (Scott 1990; Punch 1998; Macdonald 2001; Robson 2011). The bio-data and training documents are authentic official documents of the W.R.C. The bio-

data was recorded by staff of the agency (that is, by those who received induction, before conducting interviews with the service users) prior to admission and records have not been distorted. However, information recorded are those provided by the service users. In addition, the information provided was written in English language and there was no ambiguity.

I also carefully examined the instruments for achieving recovery set out in the curriculum for training by the agency (Wellspring Rehabilitation Centre 2003) and lecture notes used by the agency.

Consideration of issues of validity in the research

It is also important to consider validity in all social research studies. Robson (2002) identifies three key issues here: possible inaccuracy of data; difficulties in interpreting the informants' meaning; and not considering alternative explanations of the phenomenon being studied. The first concern was managed in the field by the use of an audio tape-recorder and listening to the interviews over and over again to ensure accuracy in transcribing the data. Interviews were transcribed in full, including false starts and sighs made by informants. Silverman (2001) suggests that the reliability of data is enhanced when observation and verbatim accounts of what people say are recorded. The second concern regarding respondents' validation was managed by getting feedback from the informants about the meaning attached to their experiences. Feedback was obtained from the informants who were service users in two ways. About half of the transcriptions that were ready during the period

of the field work were read to the participants that could not read English and those who could read were asked to go over the scripts. Clarification was also sought by telephone for other interviews once I was back in Edinburgh. This was particularly important with regard to the interviews that were conducted in the local language, Yoruba.

Regarding validity of observation, Adler and Adler (1994) suggests that one of the criticisms leveled against the use of observation method is about validity of data since observers seems to rely more on their own perceptions They argued that information gathered of settings and subjects are actually valid data and when added to other research products are valuable, provides more depth, enables cross-checking of other sources of data and improves consistency and validity (Adler and Adler 1994). Participant observation as earlier noted was carried out to supplement data from qualitative interviews.

3.4 Ethical Issues

Ethical issues are at the heart of the practice of social research; researchers must decide how to act by preparing themselves and consider all ethical concerns in their study design (Neuman 2003). Before embarking on field work, I applied for ethical permission from the Research and Ethics Committee of the School of Social and Political Science, The University of Edinburgh. The process of preparing the application was useful in assisting me to gain insights and develop sensitivity to

ethical issues that I needed to be aware of. Further discussion of the ethical issues and consideration in this research are discussed below.

3.4.1 Ethical issues involving research informants

Ethical issues involving research informants that were critical to this study were informed consent, confidentiality and anonymity, the physical, social and psychological well-being of the research informants and acknowledging the participation of informants.

Informed consent, confidentiality and anonymity

The Social Research Association (2003) proposes that studies which involve human subjects must be based on informed consent freely given. According to Wiles et al. (2005), the principle of informed consent was first stated in the Nuremberg Code of 1947 for research governance of human subjects following evidence of abuse of human research subjects during the Second World War. The Royal College of Nursing (2006) defines informed consent as an on-going agreement by an individual after risks, benefits and alternatives have been adequately explained to them to receive treatment, undergo procedures or participate in research. (See also the code of ethics of the British Sociological Association (2002).)

Specific issues regarding informed consent in this study were as follows:

1. Obtaining written consent: This was identified as important in getting informed consent from informants and I therefore developed a consent form. This contained details of the researcher, purpose of study, rights of participation and risks in participation, promise of confidentiality, purpose for which study will be put and a section for confirmation of consent. (The consent form is provided in appendix 6).

2. Ensuring informed consent from participants whose first language was not English: This was achieved by identifying likely languages (Yoruba was found to be the main one) and presenting materials in that language.

All research informants except one person freely gave their consent to participate in the study and signed the consent form. The only one person was not comfortable about sharing his experiences and was not involved in the study as an informant.

Issues relating to confidentiality included: handling and disposition of data, access to raw data, preservation of identities of research informants, uses to which research would be put and providing feedbacks to informants. To preserve confidentiality, all the informants' identities were changed by use of pseudonyms. This was important because of the sensitivities involved in conducting research among emotionally sensitive groups, as is the case with the research informants who were in drug dependency. It was anticipated that issues regarding past offences might be revealed during the interview; the researcher chose not to explore these in detail. It should be acknowledged that there could be no complete guarantee that parts of informants' stories might be recognised by members of the group being studied since they have lived together and know each other well. This was explored with informants, and it

was also stated in the consent form that disclosures regarding harm to children would be taken up. Permission was also received regarding the transcription of data.

Regarding the handling of data, it was confirmed that audio tapes would only be kept during the period of study and would be destroyed after the study by the university's confidential disposal procedure. Further, only my supervisors would have access to the raw data during the study. Everyone was made aware of their obligations regarding confidentiality of records and information being handled. Regarding dissemination of findings, these will be communicated as follows: to the board members and management team of the agency, in academic publications, and to other researchers and practitioners. Feedback will be provided to participants through the meetings of the agency's Alumni Association, through family forums and through the agency's newsletter.

Potential risks to participants

The Social Research Association (2003) code of ethics suggests that researchers should ensure that informants are protected against possible harmful effects of participating and to their relationship with their environment. Examples of potential risks identified include stress, loss of self-esteem, psychological injury. Other authors such as Neuman (2003) identifies other potential risks such as physical harm resulting from health or physical attacks and legal harm such as risk of arrests.

I was aware of my responsibilities to protect the physical, social and psychological well-being of the informants and in particular, the primary group that were still dependent on drugs. It was recognised that the research could raise some difficult emotions for some persons who were being asked to share their stories of drug dependence and recovery. I attempted to minimise this negative impact by being clear with informants about the purpose and benefits of the research and what they expect to benefit from it. I treated them with respect throughout, and undue intrusion into their personal lives was avoided by allowing the informant to tell their own story, and at their own pace. With respect to the physical safety of the research team, the researcher ensured the safety of the research team during field work by conducting the interviews in safe places, using the offices of the agencies visited. In addition two interviews with staff were conducted in informants' homes.

Acknowledging the participation of informants

Ethical guidelines stress the importance of acknowledging informants' participation in research. I wanted to express my appreciation for many reasons. Fundamentally, informants provided insights and there would have been no study without them; this needed to be conveyed to them and to others. I also recognised that it was not just participation that I needed, but willing participation so that they could be open during the interviews and contribute meaningfully to the research; again, I tried to explain this to informants in advance of interviews. In appreciation, informants were given a token for taking part in the research in terms of their time and contributions: a shirt was given to the service users and other material gifts to others such as food

packs/drinks and for some, shirt ties. Head (2008) notes that payments have been used in many research studies as an incentive to obtain participation in research, while noting that this may compromise the notion of willing participation. But from a very different perspective, refusing to pay informants may also be considered as unethical. Certainly all the informants in this study were happy to be appreciated in this way. They also appreciated being heard; this in itself was empowering for them. Being a group that is highly stigmatised, it was an opportunity to tell their stories and be involved in a project that might contribute to helping others, as one service user said:

> 'Thank you ma, God bless you ma for this opportunity. It was wonderful for me to be on this track, I appreciate it and God will strengthen you, I pray that God give you grace and knowledge and understanding, more and more to help us and help the others that are out there. Myself, I have take that determination and vowed before God, I will help to be a blessing to them.' (John: 32 years, unsuccessful and back in treatment)

3.5 Transcription of data

Fielding and Thomas (2001) note that there are two types of transcriptions, verbatim (verbatim talk without grammatical or any tidying up) and selective transcription. They argue that using verbatim transcriptions ensures that no data is lost; during transcription, it may not be possible to know what will be the most significant point of analysis. Even if selective transcription is used, they recommend that a few should be transcribed verbatim. Silverman (2001) agrees. He suggests that the reliability of

the interpretation of tape-recorded data may be gravely weakened by a failure to transcribe apparently trivial, but often crucial, pauses and overlaps. However, Kvale suggests transcripts are interpretative constructions that serve a given purpose and as such, there can be no correct answer as to what a correct transcription is. Kvale suggests that a more useful question is to consider the intended use of the transcript (2007: 94-97).

In this study, it was important to preserve the meaning expressed in each narrative so the researcher opted for the verbatim transcription, though it was laborious and time-consuming. Transcription was carried out by the researcher and with the assistance of five transcribers for two reasons: the limited time for the field work; and to enable me get feedbacks from the research informants. To limit errors to the barest minimum, I went through each interview tape transcribed.

3.6 Data analysis

Data analysis in qualitative data refers to the process of data management and interpretation (Ritchie and Lewis 2003). There are several stages in data management, which involves identification of initial themes, coding and summarising data. The analytic approach adopted for this study was a qualitative inductive process. This involved breaking down data into segments so that these could be categorised, organised and examined to obtain the main features of the data (Simons 2009).

Spencer et al. (2003) suggest that qualitative researchers need certain aids and tools to enable them to carry out a robust analysis which allows for investigation at all levels. They identify several important features of these tools. First, they provide a structure that allows ideas, concepts and patterns to be represented. Second, they permit data reduction. Third, they facilitate and show ordering of data. Fourth, they permit searching through data cases and within one case. Tools also permit the analysis of all types of data such as interviews, group, document and observation, and allow flexibility in the manipulation of data and allowing findings to be accessible to others. One of the analytical tools identified in literature which has been used in qualitative data analysis is computer-aided qualitative analysis software. Spencer et al. note that although this tool supports the analysis of data, it cannot replace the researcher's conceptual skills which are required to read, sift, order, synthesise and interpret data. Weitzman (2000) suggests that qualitative analysis software, in addition to helping the researcher to perform all the usual tasks of coding and organising of data, also facilitates speed in data analysis and supports the analysis process by storing of data in one place, saving the researcher energy for more important tasks and helping the researcher to see and follow up with relationship building.

One such computer-aided qualitative data analysis software tool, NVivo (CAQDAS), was used to support data analysis. I chose to use this, in part, because I had collected a large amount of data in the field, and this enabled me to store the data effectively. It was also extremely useful in helping me to build my analytical ideas and also in the writing stage. I was able to compare and contrast data coded in different ways (see

Bernard (2000) and work out where the interrelationships lay, using the tree nodes. Other functions including ‘search and query’ were also made easier by the software.

Describing the process in more detail, two data analysis procedures were used in the study: data reduction (i.e. coding) and data interpretation. Coding evolved through several processes. Using NVivo, I coded key themes that emerged from the research questions, interviews, and transcriptions as ‘parent’ nodes; repeated listening during transcribing facilitated the identification of these themes. Other important sub-themes which emerged from the data through the process of coding were classified as ‘child’ nodes. I induced themes from the texts by using a variety of means. These included line-by-line analysis, asking questions of the data in order to identify themes, similar phrases and contrasting phrases, and sequences of events; identifying recurring words or repeated words which suggested that the issues were important to the informant; identifying themes that characterised the experiences such as ‘I suffered a lot’. This process was facilitated by using the ‘search and query’ function in NVivo and coding in the ‘free’ node. Further, ‘search and query’ functions were used to search for regularly-occurring words and coded on ‘free’ nodes. As I identified meaningful themes, all relevant sections of the data were selected and coded. Through coding, I was able to identify and organise the data, which enabled retrieval for further analytical work, which was on-going throughout the process of analysis. Interpretations and conclusions were also made from the coded materials.

In interpreting the data, two processes evolved: re-organisation of data and interpretation of themes from coded materials. Themes and coded materials that emerged from the data were printed off and studied. I studied all the cases within each theme and noted the varieties of descriptions and meanings attached to them. Re-organisation of the data was achieved in the following ways: in some cases, codes were re-defined and irrelevant text within the code was removed; in some others, new codes were formed and text re-selected; some categories were also collapsed to have fewer categories; and within each category, descriptive items were further reduced when it was relevant to do so. For example, in the analysis of processes of recovery, 10 descriptive items were identified under the theme teachings of Biblical scriptures. These items describe the effects of teachings on recovery and were subsequently reduced to three descriptive features. To interpret the data, the texts selected for all cases in each theme were analysed. For example, in an analysis of how recovery was experienced, one of the themes identified was salvation. Similar experiences of how salvation was experienced and how this facilitated recovery from drug dependence were described and explored. Further, discussions of the findings in the light of previous findings and related themes were made for each theme.

3.7 Limitations of the study

There are always limitations in any research study; it is important therefore to be clear what these were and what impact this may have had on the outcomes of the study (Wolcott 2009). Due to constraints of both time and cost for fieldwork and

analysis, the study population was limited to informants who had and were receiving treatment in a single treatment agency.

The study is also limited by the decision to conduct a case study on one agency. Whilst this has engendered rich data about recovery in a Christian, faith-based service in Nigeria, it cannot be generalised to treatment and recovery in other settings. More research needs to be done to explore whether and how far the broad messages of this study are transferable to other contexts.

3.8 Summary

This chapter describes the research design and methods adopted for executing the research project and its limitations. It is acknowledged that the lessons to be learned from this research study are very specific ones, given the individual and contextual nature of drug addiction, treatment and recovery, and given the specialist approach of the agency under investigation. However, the methodology used in the study is applicable in other contexts, and I believe too that the main themes of the findings are also of interest to both developing and developed world settings, as I will now go on to discuss.

Chapter 4 - Conditions in drug dependency

4.1 Introduction

Understanding the conditions associated with drug dependence is fundamental to understanding how people recover from dependent drug use. Accordingly, this chapter explores the experiences of informants in drug dependency. The findings in this chapter are drawn from the qualitative research interviews conducted with the 38 research informants who were service users of the agency. The vast majority of the informants were men (31 to only seven females). Their age ranged from 15-56 years, but only two persons were under 20 years of age. They had varied educational backgrounds, being educated to primary, secondary, vocational and higher institution standards. This was reflected in their working backgrounds and current careers which ranged from students and clergy to those working in the armed forces, technicians, hairdresser, bus attendant, musician, drivers, administrators, boxer and working in catering. Marital status also varied; 11 were married, 18 were single and 19 divorced. All informants, with the exception of two persons (a Ghanaian and a Liberian) were Nigerians, the majority of whom were Yoruba people (see chapter 1 on Ethnicity). Most of the informants could speak, read and write English. Findings showed that there were three main drugs of abuse: cocaine, heroin and cannabis. Other drugs taken in combination with these drugs were alcohol and cigarettes. Most of the informants, that is, 32 persons, had been or were multiple drug users**.** Three informants had been or were primarily dependent on cocaine, and three others were primarily dependent on cannabis. Years in dependency ranged from one to 35 years; however, there were two people who had used drugs for less than two years and both

were under 20 years of age. The findings are presented in two sections: commencement of drug dependency and factors associated with drug dependency.

4.2 Commencement of drug dependency

Findings from interviews revealed that the main factor associated with the commencement of drug use was environmental influences; principally, encouragement by peers and, to a small degree, by family members and other associates. Many informants claimed that before the commencement of drug consumption, they had no previous knowledge of drugs and their effects. For example, Balak was a 53 year old male informant, who had been dependent on drugs for 25 years. He described being first introduced to drugs:

> 'There was a day a friend introduced drugs to me, even that day I did not expect what to meet what we call drug and from that day I started smoking drug after tasting it.'(Balak: age 53 years, recovered)

Those who started using drugs in secondary school as adolescents, were encouraged by their peers in school to use drugs like cigarettes and cannabis. Others, who started using drugs as adults, were influenced by peers in the community, at work, in school and started off using cannabis or hard drugs. Three of the informants, were influenced by their friends living in the same neighbourhoods, close to where drugs were sold or where cannabis was grown. Five persons were introduced to drugs in their work places by their peers at work. For example, one such person, a male informant had worked in a club as a disc jockey. He claimed he resisted the drugs being brought into the club but eventually ended up using drugs due to the influence

of the friends he made at the club. The findings clearly showed a relationship between peer influence and commencement of drug consumption. But why did those individuals accept drugs from others? Two main reasons were proffered. First, drugs facilitated socialization among peers and were encouraged at parties. For example, Elijah, a 53 year informant in the sustained sobriety group who was dependent on multiple drugs for 20 years, claimed that he used drugs because it was fashionable and made him accepted by his peer group. He claimed that 'you don't belong if you don't use drugs.' The second reason given was curiosity. However, only one informant Joana, a 22 year old informant, claimed that she was curious about drug use because everyone around her in the university was doing it, as revealed below:

> 'Well mine started out of; I started using drugs out of curiosity. Friends were, not only friends but people around me were doing these things and I was just curious. I wanted to find out what it was all about so I just picked up myself and went ahead to find out what it was all about.' (Joana: 22 years, in treatment)

4.3 Factors associated with drug dependency

Being introduced to drugs does not, of course, necessarily lead to dependency. The important questions this section therefore addresses are: what factors are associated with dependent drug use and what are the implications for recovery? Findings were centred on psychological factors, environmental influences and spiritual influences.

4.3.1 Psychological factors

The experiences of the research informants revealed that three factors accounted for drug dependency: the rewarding effects of drugs, the problematic effects of drugs and loss of self-regulatory control.

The rewarding effects of drugs

One key finding is that drug taking was viewed as rewarding and pleasurable by all the informants. All the drugs consumed gave a feeling of elation, which service users often referred to as 'being high'. This feeling made using drugs desirable and often resulted in long usage of the drugs of choice. This is captured in a quote by Theophilus, a 43 year old informant who was dependent on multiple drugs for about 10 years:

> 'During the time when I was in drug, the ecstasy or the kind of feelings we do get from the drugs carried me away to the level that before I know where I am, in fact it has been so far'. (Theophilus: 43 years, sustained sobriety)

Furthermore, for many of the informants, the experience of euphoria made them feel important, irrespective of what people thought of them. For example, Onesiphorus, who was dependent on cocaine, heroin and cannabis for 19 years, described this vividly:

> ‘Immediately ti a ba ti mu kini yen tan or by the time ti a ban mu lowo nse ni o ma dabi eni wipe ‘head of state’ ni wa. Nse loma dabi eni wipe awa on top of the moon.’(Yoruba)
>
> (Immediately we finish smoking or during the smoking, we would feel like we were the Head of State; it would be like we were on top of the moon.’) (Onesiphorus: age 56, sustained sobriety)

Drugs therefore gave users positive feeling such as self-worth. They also kept from getting worried about life’s problems. For example, Chris, a 50 year old man who was a multiple drug user for 26 years, explained that the drugs helped him not to have any worries and made him feel good about himself and proud:

> ‘Then I started smoking this thing. If you smoke this thing it will make you to be very high. You will not have any problem. It will seem all the world is inside your pocket…..You will just, pride will be on you… Any time you take it, you will feel you are alright.’ (Chris: 50 years, sustained sobriety)

Drug consumption was also beneficial to the informants in other ways. Drugs helped them overcome timidity. For instance, David, a 49 year old informant in treatment, who had been dependent on cannabis for 39 years, discovered that the drug helped him get rid of shyness, and made him a more confident person. For many others, drug consumption gave them the boldness to do anything, including antisocial behaviour such as fighting and stealing, indicative of the lifestyle lived on the streets. Saul’s experience illustrates this point. He has a small stature and used cannabis for nineteen years:

> ‘If I take it, how I feel; it’s just like when you put a rat beside an elephant. The elephant is very big; the rat will say this elephant that I want to fight with is going to beat me; but when I take the marijuana, the elephant will be like an ant by my side. That is how if I take the marijuana that is how it is in my body when I take the marijuana. So once I take it, anything I want to do is sure that it is going to be a successful one, whether good or bad.’ (Saul: 35 years, sustained sobriety)

Cannabis also provided the physical strength to work and removed body aches, particularly for those who worked long hours as bus conductors. Obed, an 18 year old informant who used cannabis for three years, explained that cannabis provided him with the strength to work better:

> ‘I do work easily because all my bones, all my muscle will rise up and I will do anything I like, I won’t feel pain at all.’ (Obed: 18 years, in-treatment group)

Problematic effects of drugs

Even though drugs evidently brought positive benefits to users, findings also showed that there were psychological problematic effects associated with drug dependence. Cocaine provided only short spells of pleasurable feelings and intense euphoria. The short spells of pleasure made the users crave the drugs and often led to frequent use of drugs. Consequently, this resulted in dependence. The experience of Titus, aged 32 years, who used cocaine and heroin for 13 years, is described below:

> ‘The first heat is about five minutes then it will come down from you ….that is you will be coming to be having it more more more because it will not last than either two or three minutes.’ (Titus: 42 years, unsuccessful and back in treatment)

Craving was described as intense and overpowering by a 51 year old informant, Osenimus, who used cocaine and heroin for 35 years. The findings further revealed that informants felt uncomfortable, sad, miserable, anxious and unwell when they had not used drugs, a feeling described by an informant John:

> ‘I will have no relaxing or nothing no no normalness until after smoking it.’ (John: 32 years; unsuccessful)

Moreover, many of the informants explained that cocaine dependency produced hallucinations which caused intense fear. In order to reduce the feelings of euphoria, service users used one or more depressant like heroin and cigarettes or alcohol although one informant said that she often drank cold soft drinks to reduce the effects of euphoria. Using depressants to reduce the intense feeling of euphoria is, in the local parlance, called ‘stepping down’. This is explained in the quote below:

> ‘When we take cocaine, is too high, cocaine will make you to high. So when we take the heroin, that heroin will step you down, will calm you down to the normal level’. (Titus: 42 years, unsuccessful and back in treatment)

Unfortunately, using depressants to remove hallucinations made dependent drug use more problematic as dependent users were faced with the effects of multiple drug

use. The short spells produced alternate high and low feelings, which was described as a feeling of well-being and depression. When the drugs were consumed, informants claimed they felt elated and good and when the effects of the drugs were diminished, they felt depressed, unhappy and annoyed. This experience made using drugs a frustrating experience such that it was difficult for many dependent users to stop using drugs. Balak's experience illustrates this problem:

> 'So as am going on, going on like that, everything change, finally in my life, then sorrow come in, bitterness come in, there is no happy, no one day I can be able to happy, but immediately I take drug I will feel happy that I am cure in jouncing. But for some hours when that happiness stop, I will come back to sorrow again.' (Balak: 53 years, stained sobriety)

Findings showed that heroin was used not only because it provided pleasurable feelings, but also for the avoidance of withdrawal symptoms, often described by informants as 'jouncing'. For example, one of the withdrawal symptoms associated with heroin was body pains. Onesiphorus, a 56 year old informant who was dependent on multiple drugs for 19 years, claimed the effect of the body pain was so severe that dependent users felt like committing suicide, robbing or selling their own child to obtain money to purchase drugs and avoid the symptoms. Balak explained that jouncing could only be solved by using drugs. This was described by many informants as 'curing'. Jouncing was also experienced as body weakness by many informants such that the user would find it difficult to talk, eat or take a bath and consequently, would always look dirty. This made it difficult for a dependent user, to hold onto a job. Balak suggested that jouncing makes a dependent user become 'a fool, a dead person or a leper'; suggesting that the person is helpless or useless. He

added that until withdrawal symptoms are removed, the dependent user would be compelled to do anything to obtain drugs. In addition, Kenneth, a 51 year old informant who was a multiple drug user, claimed that another symptom experienced is over-sleeping. He suggested that when sleep comes upon the individual, he sleeps anywhere he can lay his head, even in the rain, with just nylon as cover. This often led to drug users getting killed accidentally. The quote from Balak's interview transcript, illustrates this experience:

> 'And there is something they call jouncing, that jouncing; make man to destroy in this life. That jouncing is the real problem in drug; there will jouncing in the morning, there will jouncing in the afternoon, and there will jouncing in the night. And this jouncing if it is not cured, it continues gradually like that, your leg will be weak, you hand will be weak, even to talk is a problem, even to eat is a problem, unless you take that drug. No time, you will not be looking for washing cloth, you don't have time again, when you off your cloth, when it dirty, you throw it away you look for another one, because you don't have time for that again. And when you have any thing that is good in your house, you will use it for smoking, even you have it in your body, you use it for smoking. If it happen that you are working in anywhere, you cannot last more than three days, you stop without nobody stopping you, because of that jouncing. ' (Balak: 53 years, sustained sobriety)

Loss of self-regulatory control

21 informants claimed that one of the problematic effects of drug dependency was the loss of self-control often expressed as 'I did not get myself', 'I could no longer control myself'; 'I did not have power to help myself'; 'I was not myself'; 'I smoked almost many years without getting myself'; 'I lose my memory' 'I became half-mad man', 'I lose my memory'; 'no normalness'; 'I don't want to know about nothing or think about nothing'; 'all I think is about drugs and how to get money to smoke drugs'. Loss of self-regulatory control was evidenced by several failed attempts to quit drugs. The interventions accessed in the past included medical, traditional, Christian treatment agencies, and self-attempts. Users continued to use drugs in spite of negative effects such as arrests by security agencies, harsh living conditions, homelessness, separation from and death of loved ones, ill health, negative attitudes from the society, imprisonment and even near death experiences. The effects of loss of self-regulatory control often resulted in a state of despondency, a desire to get help to stop the habit and looking up to God for help. Phoebe's experience illustrates this point.

> 'I started smoking until one day I was tired …. So I say God am tired of this thing, help me. Even in the joint I will be praying, I will be praying, I will be talking to God; I say help me father, I know that I have done something wrong forgive me help me I want to go out of this thing I don't know how to do it help me. I will be crying.' (Phoebe: 45 years, sustained sobriety)

4.3.2 Environmental influences

One main environmental factor which led to drug dependency was the influence of drug using neighbourhoods. The data reveals that there were several drug using neighbourhoods called ‘drug joints,’ an integral part of Lagos city, which has a distinct social life and values and activities that promote drug dependence. Drugs are both sold and consumed in those neighbourhoods, which may either be compounds where people reside, or shops where people buy and sell. The results suggest that two groups of people patronise the joints; the dependent users who left home to live in the joints or in the streets and other types of users including those who use drugs on a more casual basis. One of the informants, Daniel, a multiple drug user of 12 years, suggested that a dependent drug user sleeps on the streets is likely to be uncomfortable in his home and looked down on. Those who do not live in the joints but come around at night to consume drugs are disparaged by those who live in the joints. Daniel suggests that they call them ‘o yo wa,’ meaning someone who ‘sneaked out of the house’ to use drugs or ‘omo mummy’, literal translation meaning mummy’s child, but the meaning also implies they are under mummy’s control.

Not only that, most of the informants explained that the joints do not have accommodation for their clients, because the joints served as places for smoking and not for sleeping. One informant said some joints have wooden buildings, where up to 20 dependent users of both sexes sleep in one room and they sleep sitting or standing, due to lack of space. However, most said that dependent users (male or female) most often slept in the streets, on or underneath tables where goods were being sold; in the

cold, rain or heat, mostly in unclean places. For those who slept on tables, when the owners found them there in the mornings, they would drive them out in a hostile way, by pouring cold water on them and using abusive words against them. Others slept on cardboard on bare floors throughout the night. As a result, many dependent users died in their sleep. Some also woke in their sleep and were killed by vehicles. The quote below is indicative:

> Drug addicts, sleep in the street, they sleep under the ganta. That's it.' (Daniel: 42 years, sustained sobriety)

Life in the joints was described as terrible by many informants. Fights often broke out between the drug users and the local vigilante group Oodua People's Congress (OPC) which sometimes resulted in loss of lives. In addition, they were frequently raided by the police in search for criminal offenders as this excerpt reveals:

> 'This is how I've been living that life and it has been a terrible life; because in the joint there is no, it's not convenient, in the rain I will be sleeping beside gutter, I will be sleeping beside the gutter the owner of the joint might come at any time drive us out, police may come to raid; at least I have got a kind of, let me say at least a close shave with death when they come into the joint to raid.' (Theophilus: 43 years, sustained sobriety)

Some informants described their experience in the joints as being enslaved to drugs and the drug sellers. This is because as dependent users, they spent most of their income on drugs and felt like they were being used like slaves. This experience is explained below:

> ‘I am now sleeping in the joint with them, smoking, working as a junkie for the dealers. And when the dealers know you are a junkie; a junkie means people, who has put their lives on drugs, specialise on drugs that they know this man if he does not take drugs, he cannot do anything that is a junkie.’ (Balak: 52 years, sustained sobriety)

The informants also bemoaned the lack of medical care in the joints. This situation resulted in the loss of lives of many dependent users whose bodies were dumped in the waste containers or the lagoon and were never given a decent burial.

Regardless of these negative experiences, many informants at some point in their drug using careers left home to live in the joints for a long time and in some cases up to 30 years. Only three people in this study (a male and two females) had not spent some time living in the joints. 15 were family men who had abandoned their wives and children. Most of the informants had lost contact with their families during their sojourn in one or more joints. But why did they stay there? Findings from the study demonstrate that drugs were easily sourced at the joints and provided a place to use drugs in the company of others. This shared interest, value, and cohesion also encouraged drug dependency. The experience of Michael explains this point:

> ‘When I wake up to smoke and drink and em you cannot enjoy it alone, so definitely you would still need some friends that do the same thing. So when you started in the morning with friends you might end up spending the whole day in the joint, because people are coming in and people are

> going, the time is always there and it means a lot to those who sit down one place to enjoy themselves. (Michael: 47 years, in-treatment)

What is more, the informants suggested that the drug dealers were able to provide them with drugs to remove withdrawal symptoms which in turn helped to keep them dependent on drugs. Hence, they were made to be dependent on drugs through the continual source of supply, and through the opportunity to get rid of the cravings and withdrawal symptoms. This meant that they could go out and source funds to pay the morning dose and obtain more drugs. The quote below illustrates this point;

> 'In the morning when I wake up in the joint, they will give me the curing. That curing mean that just to cure for the mean time and look for money, and when I come back I will pay the money to the chairman who sell the drug for me. In the morning when I wake up, my body will so feel so weak; I won't be able to do anything unless when I have the curing. Immediately I take the curing, my body will come back to normal and I will begin to have another thinking, how I will get the money to smoke.' (Abathiar: 50 years, sustained sobriety)

The joints also provided places for communal support and bonding, because in the joint, they shared a common interest and a pleasurable experience in using drugs. According to Benjamin:

> ‘Hmm, Very very horrible, but then it was the best thing someone can experience.’ (Benjamin: 52 years, sustained sobriety)

Some others said that the joint was where they felt happy and comfortable to be because they were highly stigmatized by society and rejected at home. For instance, Chris claimed that the only people who made him happy were his drug using friends. Balak also confirmed this, saying that he felt happy whenever he was using drugs in the company of fellow drug users:

> ‘Like me when I smoke coco, I feel happy, I talk with people, I make fun, when I begin talk story ah, people will like it, it is because of that coco wey I carry, make me dey talk that kind story, all that kind history the thing wey no happen, that is my own life. And immediately that coco wipe away, if them say this is man that is talking that time yesterday, you will not believe it, you will see me quiet, a useless person.’ (Balak: 53 years, sustained sobriety)

In the case of Theophilus, his only source of support, his mother, died when he was drug-dependent. He was rejected by his family, so the only place he felt he could live was in the joint:

> ‘During this period, I have lost my mother who I could say it might be as a result of my em waywardness that make her to have a stroke and from there she died. So I was left on my own in the joint I was staying in the joint but what do I do?’ (Theophilus: 43 years, sustained sobriety)

4.3.3 Spiritual influences

Evidence from the study also revealed that spiritual influences were associated with drug dependency and the informants explained this in two ways: from African perspectives and from Christian Pentecostal perspectives.

African ideas of spiritual influences

Seven persons claimed that people are affected by malevolent forces to consume drugs through direct influence of the spirit of drugs and indirectly through dreams. They believed that there was a spirit behind every drug and that drug consumption was influenced by negative spirits, which had controlling influences over persons who were dependent on drugs, and kept them bound to drugs. This was outlined in a number of ways. First, some persons claimed that through spiritual influences, they received insights of how to get money to maintain their habit, by stealing, defrauding people and committing robberies to sustain the drug-dependent lifestyle. For instance, Daniel claimed that the spirit of drugs controlled a person by telling the individual how to get money and by being accurate about details:

> ‘You know, you know, ti eniyan bamu drugs, spirit to wa ninu drugs yen, ohun lo mama contol eyan, Is a devilish spirit. O mama control eyan kakiri.’ (Yoruba language)
>
> ‘(You know, you know, when a person is taking drugs the spirit behind drugs will be controlling a person. Is a devilish spirit. The devilish spirit will be controlling the person all over). It is the spirit will tell you what to

do to see money. Then I will see the money, ma ri owo yen by all means (I will get the money by all means).' (Daniel: 42 years, sustained sobriety)

The implication of this is that they had continuous sources of funding to be able to maintain their habit for a long time. For example, Abathiar, who was dependent on drugs for 31 years, described this as follows:

'Immediately I finish the money another thought will come, that's the spirit of heroin. It will give me another experience, another way to discover to get the money.' (Abathiar: 50 years, sustained sobriety)

It was also believed that the spirit of drugs encouraged cravings for drugs. For example, Titus was dependent on drugs for 13 years and he explained that the spirit of drugs not only revealed to him how to get money, but also commanded him to go and use drugs immediately after obtaining the money. He therefore associated the urge to use drugs to the spirit of drugs.

'It is the spirit of this drug that will tell us that go to so so so place you will get money there, go to so so so place, go and lie for them there you will get money. Immediately you get there, it is the spirit of that drug that will tell you don't go to anywhere o, you will get that money. Go after that smoke straight. That is what I mean by… the urge is the spirit.' (Titus: 42 years, unsuccessful and back in treatment)

Furthermore, another informant Silas claimed that he often heard voices which compelled him to use drugs:

> ‘Well it’s a spiritual problem because you don’t have control over yourself; over the urge of it, you don’t have control over it. Because if you make up your mind that yes I am not going to take it but there is an inner voice in you that will be controlling you, telling you that you need to take these drugs, you need to take these drugs. It will be controlling you, it will be giving you visions of how you feel when you take the drugs things you do and all that, telling you just look at how you are feeling now very uncomfortable, stressed out, you are not yourself but just take this drug and see how you feel, that is why I say it is a spiritual problem because that voice will keep on persuading you until you take the drug, then when you have taken the drug then you feel relaxed then the voice will tell you how do you feel now, so that is why I say it is spiritual because it is that voice that is always talking to you, keeps telling you to do evil.’ (Silas: 27 years, in-treatment group)

Some informants also revealed that whenever they tried to stop using drugs and dreamed of using drugs again in their dreams, they resumed use. This made it difficult for them to stop using drugs. For example, Phoebe was dependent on cocaine for 16 years. She said she made several attempts to stop using drugs but always returned to using drugs whenever she saw herself using drugs in her dreams.

> ‘If am sleeping, the day I dream that I smoke this thing, I must go and smoke, I will not come back…..’ (Phoebe: 45 years, sustained sobriety)

Pentecostal Christian perspectives on spiritual influences

Christian Pentecostal explanations for drug dependency focussed on spiritual blindness and on demonic bondage.

Two informants stated that spiritual influences were responsible for keeping users blinded from the realities of the problem of drug dependence. For example, Michael, who was dependent on drugs for 28 years and undergoing treatment at the time of the interview, explained that he thought most drug addicts were talented and intelligent people who had not been able to achieve their potential in life because they were spiritually blinded. He explained that it was the devil that made them satisfied with their present condition, and made them believe that they could not make it in life again.

> ‘So it is a spiritual blindness a veil that covered on people’s eyes for them not to see the will and purpose of God in their life so that is it, it has happened to so many people, I have been a victim.’(Michael: 37 years, in-treatment group)

The findings also revealed another spiritual aspect to drug dependency, demonic bondage. One informant claimed that drugs took control over a person, and kept a person under bondage. Theophilus asserted that:

> 'Drug is like one bind with a chain that is more powerful you cannot get loose out of it; it it is a kind of bondage, a stronghold on you that you don't have power, even though you have the willingness to leave, but you don't have the mind or the power to say that you want to leave the the habit, so I still have to continue.' (Theophilus: 43 years, sustained sobriety)

Because of this, users had attempted to resolve the problem several times without success. They continued depending on drugs, despite negative effects, including poor health, arrests and imprisonments by law enforcement agencies, physical sufferings and emotional pains. This was evidenced by the words 'I can't just help myself'. For example, Phoebe, in her attempt to stop using drugs travelled out of the country several times but always returned to drug dependency, whenever she dreamt about using drugs or found where drugs were being sold. For many informants, stealing became a way of life, and other people, outside their group, did not mean much to them. For example, Balak said that as soon as he started consuming drugs, his personality changed: he started telling lies, doing negative things to source drugs, his body changed and his thoughts changed from good to bad, so that, he was always having bad thoughts and stopped having good thoughts. He was in this condition for 25 years.

4.4 Summary

Findings in this chapter were discussed under two topics: commencement of drug consumption and factors associated with drug dependency.

The major factor associated with the commencement of drug dependency was found to be related to peer influences. Although the findings suggests that first time users were ignorant of the effects of drugs, drugs was found to be a means of socialisation and provided a sense of belonging to the social group. But why did drug use lead to drug dependency? Three main factors were significant here: psychological, socio-environmental and spiritual factors. Psychologically, findings revealed that all informants found drug taking rewarding and pleasurable. However, drug-dependent use was also problematic in two ways. First, cocaine dependency provided only short spells of pleasure which led to frequent uses and also caused intense euphoria, which resulted in dependence on heroin and alcohol, to suppress the effects of euphoria. Consequently informants who depended on cocaine, with the exception of two persons, were dependent on heroin hence experienced more problematic drug use. Second, problematic effects of heroin were related to severe withdrawal symptoms. Another factor associated with drug dependency was loss of regulatory self-control, expressed by informants as 'I did not get myself'. The implication of these findings is that informants claimed that they remained in drug dependency for a long time, between 10 and 35 years for most informants and they could not resolve drug dependency on their own. The main environmental influence associated with drug dependency was the influence of drug using neighbourhoods, called 'joints', which

facilitated easy access to drugs and dependence. Drug dependency was associated with negative spiritual influences which bound them to drug dependency, such as, dream influences.

The findings discussed have important implications for engagement in treatment and for recovery. Since findings showed that drug dependency is a difficult problem and drug-dependent users find it difficult to resolve drug dependency on their own, the question it raises is, ‘how do dependent drug users recover from drug dependency?’ This question is addressed in the next chapter.

Chapter 5 - The process of recovery

5.1 Introduction

The literature reviewed showed that the idea of recovery has been presented in stages, such as the five stage model of recovery proposed by Prochaska et al. (1992). Brought together, recovery is commonly presented as involving three stages: motivation, disengagement from drugs and maintenance of recovery. To explore how dependent drug users recover from dependent drug use, this chapter explores the experience of recovery in each of these three main stages of the recovery process. In addition, the chapter will seek to identify evidence from recovery.

Motivation for recovery was explored with all 38 informants in interview. The experiences of disengagement from drugs and sustenance were explored with two groups of people: 14 persons in sustained sobriety (two to five years), and 13 persons in the in-treatment group (five months to two years of post-sobriety), making a total of 27 persons. In addition, post-treatment challenges were explored (with 14 persons in sustained sobriety and only the in-treatment group in vocational training) to provide better understanding of the problems faced and how recovery was drawn from interviews with informants in vocational training and service users who had completed treatment. Data from interviews with family members and agency staff were used to support findings with service users. Furthermore, evidence on recovery was drawn from interviews with informants in vocational training and sustained recovery group.

I present the findings in this chapter into four sections: motivation for recovery, the process of recovery during treatment, maintenance of recovery and evidence of recovery.

5.2 Motivation for recovery

For many years, remission from dependent drug use was viewed as impossible by society and by drug-dependent users themselves, hence the use of the adage, 'once an addict, always an addict'(Biernacki 1986). However, evidence shows that dependent drug users do recover from drug dependency (McIntosh and McKeganey 2000). One of the factors recognised as important in initiating this process is motivation. For example, Di Clemente (2003), on addiction and change, suggests that motivation is an important factor in initiating and achieving behavioural change from dependent drug use. Since findings from chapter four suggest that many informants were dependent on drugs for several years, and all informants suggested that they found it difficult to resolve drug dependency on their own, this factor will be explored in this chapter. Findings were drawn from interviews conducted with all informants. For the purpose of analysis, these findings were classified into three groups: psychological, socio-environmental and spiritual factors.

5.2.1 Psychological factors

Two important factors were identified: tiredness from using drugs and self-re-evaluation.

Tiredness from using drugs

Thirteen informants claimed that what motivated them to seek help is that they had reached a point where they were tired of continued dependence on drugs. Of this group, 11 had been using drugs for between 9 and 31 years, and two persons between seven and nine years. A key reason for enrolling for treatment was an inability to stop using drugs after several years in drug dependency. For example, Lazarus, who was dependent on multiple drugs for 21 years, said that he found it difficult to stop using drugs on his own even though he recognised that drug taking was not good as shown in the quote below:

> 'You see I have been trying on my own even when I know smoking drug is bad but I have been trying I cannot do it so when I now hear of this program so I make up my mind to come again.' (Lazarus: 40 years, unsuccessful and back in treatment)

Findings suggest further that the harsh experiences associated with using drugs which many referred to as 'suffering,' made dependent drug users tired of their lifestyle and provided the motivation for change. For example, an informant, Theophilus, described his drug using experience as 'terrible'. Although he said he was trained in aluminium works, and came from a royal family in Egbaland, (Western region of Nigeria), he lived in the joints as a dependent drug user and sustained this habit by both fraudulent activities and legally through manual labour, carrying goods for people in the market. He claimed that one day as he was carrying the goods, the experience of pain and misery associated with his lifestyle in drug

dependency caused him to reflect on his former good life. He said he compared his former life as a non-drug user, with the sufferings he was experiencing as a dependent drug user; he broke down and cried to God for help to stop using drugs. In addition he claimed he was fed up with the harsh experiences he had to go through, in order to maintain the drug habit. He said God touched his heart, and he took the opportunity to seek treatment when the offer came.

> 'Em, em , err, during those days, although I do sit down and cry after God, that God should help me; that I don't want to go back because that's why I keep saying that it is God, because the problem was so overwhelming and sometimes I will sit down throughout the night I'll be thinking and I'll be crying. I always beg and I plead to God that God, if only you can bring me out. Until one time somebody tell me about em Wellspring people that em they are providing rehabilitation for them. Then, I now look at it as an opportunity for me to because already in those days I could say I'm fed up; I was only looking for help any how that help could come out because it's something that I could no longer bear though I could not help myself. So when I hear that there is a help somewhere, I immediately rise up for it and I come down to Wellspring' (Theophilus: 43 years, sustained sobriety)

This narrative reveals drug dependence as a problem that was overwhelming. Theophilus cried to God for help, not knowing a way out. His suffering acted as motivation to get treatment and recovery

The effects of separation from loved ones and the death of loved ones also made some persons get tired of their drug using lifestyle and motivated them to enrol for treatment. Four persons (Silas, Mushi, Abathiar and Kenneth) attested to this. For example, Silas was a university undergraduate when he dropped out due to the influence of drugs. He was dependent on cocaine, cannabis, alcohol and cigarettes for 12 years. Silas claimed that his drug using lifestyle created a distance between him and his family and this was an important factor in motivating him to seek treatment.

> 'I was actually fed up and tired of the life of drugs, tired of it, tired of what it has done to me physically, tired of what it has done to me emotionally because it created a big gap between me and my family, one, the world entirely, because I had to steal from around me, I was a drug user, I was a bad boy, so I just really needed to quit and I couldn't do it on my own.' (Silas: 27 years, in-treatment)

This account shows that when informants reached a point that they were tired of their drug using lifestyle, they lost the desire for continued dependence on drugs and the associated lifestyle. Although this provided motivation for recovery, however, they felt unable to stop using drugs on their own.

Self re-evaluation

Another source of motivation for recovery was the ability of some informants to reflect and evaluate themselves with respect to their drug using lifestyles. 13 informants claimed that they were motivated to seek treatment after they were able to reflect on their situation. 10 of these persons were drug-dependent for 12 to 31 years and the remaining three persons were dependent on drugs between four and seven years. Their thoughts bordered on several issues such as certainty of impending death if they continued using drugs, lack of fulfilment, displeasure with the drug lifestyle and realization of a wasted life. For example, Daniel, a 42 year old, who had depended on cocaine and heroin for 12 years, claimed that he thought about his situation on a daily basis when he was at the joint. He had two main concerns: first, he witnessed the death of many of his drug using associates and he often thought that he would die one day if he did not stop using drugs. Second, he also said that he often thought about the bad things he had done through the influence of drugs and wondered if he could not turn around and do good things in life. He also pondered the loss of people that were important to him, like the death of his son and separation from his wife, and wondered if that was how he would continue in life. He also thought about how he might make a change from his drug using lifestyle. He said he believed that it was the constant re-evaluation of his negative past experiences that motivated him to enrol for treatment.

> ‘Emi ma’n ro gbogbo awon nkan ti mo ti lose. Ki se pe nkakan sele si mi. Mo ma ro pe, aha, se bi mose mama balo re? Se bi mose mama ba lo re? I did a lot of things, Ni ojojumo gbo aiye mi, mo ma, nro pe, bawo ni fe je

nkan? Ironu yen lo je kin wa si ibiyi. Ki se pe nkakan happen si mi.' (Yoruba language)

('I often thought about these things that I have lost, and if this is how I am going to go on in life; is this how I'm going to go on in life? I did a lot of things. Every day of my life I thought about how to make a change. These thoughts motivated me to come here (Meaning, enrol for treatment.) Nothing happened to me.') (Daniel: 42 years old, sustained sobriety)

5.2.2 Socio-environmental influences

Experiences related by the informants in interviews showed that six socio-environmental influences motivated recovery. These were: negative treatment by members of society, death of loved ones, changed lifestyles of former drug using friends, supportive family relationships, negative impacts of drug-dependent lifestyle and the offer of treatment.

Negative treatment from members of the society

Negative treatment from other members of society was said to have played an important part in providing motivation for recovery. Many informants experienced verbal abuse, alienation and outright rejection from family members and other members of society. Balak's experience provides a good illustration. Balak, a multiple drug user, had used cocaine, heroin and cannabis for 25 years. He claimed

that he was motivated to quit because of the humiliation he was subjected to by members of the society: derogatory verbal abuses such as being called ‘stupid’ or ‘mad man’. He said that the disrespect he received, lack of recognition, lack of a voice, and outright rejection by members of his family motivated him to enrol for treatment:

> ‘People abuse me, people take somebody as a stupid man, nothing you can do, even you have anything, people just look you as if you are not human being, even you talk they just get you out, they don’t want to listen to you, because anybody smoking drug in the midst of those people who are talking, they count him to be a mad man, because he is an addict. One day I decide, I decide to leave drug…….My family rejected me, sister, mother everybody rejected me.’ (Balak: 52 years, sustained sobriety)

Another experience of negative treatment was alienation from former drug using friends who had stopped using drugs. Elijah was forty nine years and had been dependent on cocaine, heroin, and cannabis for 20 years at the time of interview. According to him, what motivated him to enrol for treatment was the rejection by his former drug using associates who had enrolled for treatment at the agency and had recovered from dependent drug use. He was looked down upon by people with whom he had shared a common problem as former drug users who were alienated and despised by society, and with whom he had bonded with in the joints. He described the situation as shameful and dejecting,

and started praying to God for a way out of drug dependency, as the quotation below reveals:

> 'And when they just came back into our midst and we saw them they were shining, plumpy and things like that. Then we started asking, they told us they have graduated o, they cannot speak to us. You can imagine how shameful it would be, somebody you've been hustling together, when next you see the person, the person is looking down on you.' (Elijah: 53 years, recovered)

Death of loved ones

Another factor which motivated recovery was the death of beloved family members. Five persons described losing their parents, but I will draw on Abija's experience for illustration. Abija, a 47 year old informant, was a professional boxer and one time African boxing champion. He was dependent on heroin and cannabis for 22 years. He had attempted to stop using drugs several times without success through the assistance of his parents. He claimed that after he lost both parents whom he had always turned to for assistance and who had always supported him in the past with treatment (indigenous traditional treatment), he realised that he did not have any support left. He said he felt the loss, despaired from being alone and felt he needed a change. This situation was compounded by being separated from his wife and children, not having a legal means of earning a living, being stigmatised and not being satisfied with his drug using condition. His expressions were strong regarding his loss and he claimed that this condition motivated him to change:

'So igbati o de ya ko to dipe mo wa sibi bayi nigbayen, pelu pe okan mi ko ti duro ni ibi bayi, okan mi ko ti true lati fi sile. But igbati o wa ya ti mama mi ku, ti baba mi ku ti mio ni enikankan mo, emi nikan soso ni okunrin ti won bi mo wa wotun wosi, iyawo mi ti lo gbogbo won tilo mio ni nkankan mo. Ha! Mo wa wope iru life wo ni eleyi, mowa di atoroje to di pe awon eyan gan ti nsa funmi. Were gan better mi to jepe mo kan wa bi eni ti koni eyan mo.' (Yoruba language)

('Later, when I came here at that time, I had not made up my mind to leave drugs. But later, when my mother died and my father died, and I did not have anyone again, I am the only male son that they have. I turned right and left, my wife was gone, everyone is gone, I don't have anything again. I now thought that ha! What kind of life is this? I had become a beggar to the extent that people ran away from me. Even a mad man is better than me. So I became like someone who does not have any one again.') (Abija: 48 years, unsuccessful and back in treatment)

Changed lifestyles of friends formerly drug-dependent

Three informants said that motivation to abandon drug dependency was realised when they saw the physical changes in their friends who used to be drug-dependent. This factor had an instant impact, because on seeing these changes they immediately sought help. For example, 56 year old informant Onesiphorus, who depended on cocaine, heroin and cannabis for 19 years, explained that he came across an old

friend on the street at Ebute-meta in Lagos and was shocked to see that his friend was 'cleaned out'. This term confers two meanings: first, it meant a clean and sober appearance that is free from the physical effects of dependent drug use such as being dirty, unwashed and looking rough. Second, it also meant being abstinent from drugs. On seeing the change, he thought 'God who changed my friend is able to do same for me' and he asked to be taken to where he had been helped.' His account is presented below:

> 'Brother Balak iwo ni yi? Iwo ti o jewipe a jijowa rugged ni garage ni olorun ti clean bayi?. Ha! Nkan ti Olorun se clean e bayi, ibi ti Olorun se kiniyi bayi fun e, iwo na ma mumi de ibe.' (Yoruba)
>
> ('I said to him, brother Balak, is this you? You that both of us used to be so rugged at the garage has been cleaned out? What God did to clean you, where God did this for you, you will take me there.'). (Onesiphorus: 56 years, sustained sobriety)

Influence of supportive non-drug- using associates

The influence of supportive associates such as friend and family members, individuals and church groups who evangelise in the drug joints, helped seven informants to stop using drugs. Saul's experience provides an example of support received from a friend and a family member. He was 35 years old at the time of the interview and had been dependent on cannabis for 20 years. During this period, his

mother and sisters supported him and he did not leave home to stay at the joints. He was motivated to stop using drugs when he met an old friend with whom he used drugs in secondary school and who had come off drugs and attributed his new status to receiving Jesus Christ into his life. This friend now began to come to his house and confronted him about his drug using lifestyle and also asked him to surrender his life to Jesus Christ so that he could be free from drug dependency. Although he rebuffed him and did several things to keep him off, Saul said:

> 'But this friend never leave me, he was still preaching the gospel to me.'
>
> (Saul: 35 years; sustained sobriety).

The friend's insistence made him decide to change his lifestyle and stop using drugs. So he followed his friend to his church, the Redeemed Christian Church of God Hope Hall on Jimoh Odutola Street, off Eric Moore road, Surulere, Lagos. During a counselling session with the pastor, he was asked to bring his mother and they were both informed about the agency. At the time of the interview, Saul had abstained from cannabis for four years and was about to take up a post as a parish pastor in the Redeemed Christian Church of God. In an interview with Saul's mother, she took up the story:

> 'The following day I went to Wellspring and I met the house manager there and he said they are admitting a new set next week. So I said ha! Can my son come along with these new people? And he said yes! Because there are two vacancies left. So I said good enough. The following week, I packed his things we went to Wellspring and they

admitted him there. And I was always visiting him to give him encouragement.' (Faith: family)

This interview demonstrates the important role of family in recovery. It suggests that Saul's mother gave him the necessary support to enable him to enrol for treatment when he decided to stop using drugs.

Furthermore, two persons were motivated by the support received from individuals who evangelised in the drug joints and three persons were motivated by the interaction with the church group from R.C.C.G. Jesus Sanctuary, Surulere, Lagos.

Negative impacts of drug-dependent lifestyle

Although all informants had negative drug using experiences, findings indicate that for three, the negative impact of drug dependency (social, physical and health related) motivated them to seek treatment. From the social angle, negative experiences included confrontation and arrests by the law enforcement agents, imprisonment, physical assault from other members of society and near death experiences. For example, one informant, John, claimed that after several arrests and a near death experience while in detention, he decided, alongside his friend, to enrol for treatment. John was 32 years old, and had been dependent on cocaine, heroin and cannabis for 13 years. He funded his drug habit through illegal means such as stealing and robberies and was often apprehended by law enforcement agents and locked up. He said:

> ‘I got caught so many times by the police locked up in police station; police would now keep me for some days, after, police would now release me. Still I would still now go back to the drugs. So it came to a time that I nearly die, I nearly lose my life…’ (John: 32 years, unsuccessful and back in treatment)

Dathan’s case also illustrates this point. Dathan was dependent on cocaine, heroin, cannabis and alcohol for 20 years and funded his drug habit through illegal means such as coning people and conducting robberies. He explained that after a near-death experience when he was almost beaten to death by a vigilante group in Lagos, he seriously thought about quitting drugs and started praying to God to enable him enrol at the W.R.C. His describes his experience:

> ‘They beat me unconsciously. That is why I get this, my eye, eye problem. So, I con think in my mind say ah! If I’m still continue like this, I will die one day. Because I cannot breathe very well again because of that beating that I, they have give me. I say, as I’m thinking this thing, I’m praying. In my closet when I want to sleep I will pray say God, help me oh! Help me oh! This rehabilitation centre I want to go there.’ (Dathan: 45 years, sustained sobriety)

Furthermore, negative health effects resulting from drug dependency motivated one informant to enrol in treatment. Matthew was 40 years old at the time of the interview. He had been primarily dependent on cocaine for seven years, and also used alcohol to relieve the effects of cocaine. He depended on stealing to maintain dependent drug use. He was once arrested and spent seven years in prison. After his

incarceration in prison, he resumed using cocaine and did not bother to return to his wife and four children. He continued stealing and also sold his blood to fund his habit. One day he collapsed. After this, he still continued to use cocaine until his body could not hold up any more. He was very ill and wanted to die. He often thought of committing suicide but he held on, and finally sought a place to enrol in treatment:

> 'I was looking for a place to chill out because my life, I con live a life, even myself my body, I was afraid of my body; I cannot move, even I dey move I dey shake, I go dey shiver I go dey look.' (Matthew: 40 years, in-treatment)

The offer of treatment

Findings revealed that the offer of treatment not only provided the motivation for change, it enabled informants to take a positive step to enrol for treatment. This was enabled through direct contact made by the agency, former service users and referrals such as evangelism groups, concerned individuals and families. Furthermore, experiences of the informants varied regarding their preparation for treatment and this can be categorised into two: those who had been contemplating enrolling for treatment and those who were still actively engaged in drug use and had not thought about quitting drug dependency. For those who had been contemplating, they were already tired of dependent drug use and sought a way to be helped without knowing how this could be possible. Therefore, when the agency offered help, many informants seized the opportunity. The offer to take people out of the joint for

rehabilitation was referred to by some informants as 'Noah's ship' that came to their rescue. The rescue by 'Noah's ship' was likened to the Biblical story (Genesis chapters 7-8) in which Noah's ship rescued his family from a devastating flood. One informant, Balak, who had been drug-dependent for 25 years, had been contemplating quitting using drugs and claimed that he knew the only way he could change was through divine intervention because he had tried several times to quit drug dependency without success. Therefore, he seized the opportunity offered by the agency, to be free from drug dependency. The quote below summarises this finding:

> 'One day I decide, I decide to leave drug. Then I saw people calling people to chill out, then I say where? They say this is divine chilling, that Jesus is calling you people. Oko Noah, se mi ni wo oko Noah? (Noah's ship, will I not enter Noah's ship? I say o.k.' (Balak: 52 years, sustained sobriety)

The evidence above shows that informants not only reached a point where they wished to stop their drug use, they got the support they needed to enrol for treatment, since they said they could not stop on their own. The offer of rehabilitation provided a significant step towards treatment and recovery.

The importance of the offer of treatment to persons not contemplating change will also be explored. Obed's experience is illustrative. He said he was on his way to source money as a bus conductor and on sighting the church bus from the R.C.C.G. Jesus Sanctuary which was usually used to convey drug-dependent persons to

treatment, he decided immediately to join them and take advantage of the assistance being offered. This is revealed below:

> 'I came here through Jesus Sanctuary. Because that day was on Sunday when I was at a junction at Idioro, I was looking for where to go; whether I should go Ijora or go Eko to go and hussle for money. But suddenly, I looked at my back, I saw a bus, they wrote Jesus Sanctuary at the back and at the front of the bus. That is not the first time I have seen the bus so I said this bus has come again, o.k. let me go and pack my load and leave this place. That is how, I came here.' (Obed: 17 years, in-treatment)

5.3 Disengagement from drugs

Research suggests that breaking off from drug dependence is an experience which is often difficult, stressful and uncomfortable, particularly in the first few days (DiClemente 2003). This section explores service user's experiences of disengagement from dependent drug use. Findings are discussed under three themes: psychological, socio-environmental and spiritual.

5.3.1 Psychological factors

Findings from informants showed that self-help processes such as cognitive re-orientation, commitment to treatment and positive self talk were important when disengaging from drugs.

Cognitive re-orientation

Cognitive re-orientation was attributed to the teachings received during the treatment period. Hope for a better life, came from the realization that being alive is an opportunity for change, unlike friends who had died using drugs. Two examples clearly illustrate how the teachings brought about re-orientation, which provided proof that this is an important factor in the recovery process from drug dependency. First, Dathan claimed that during the in-treatment programme, he encountered change when he received the lecture on the fruit of the Holy Spirit; Bible scripture, Galatians 5: 22. He learnt that the fruit of the Holy Spirit, meant 'love, joy, peace, the ability to be long suffering, goodness, gentleness, perseverance, meekness and faith'. He said he understood that when a person is 'walking in the spirit', that is engaged in spiritual lifestyles, he will be able to overcome the lust of the flesh which makes a person sin. In addition, he said he realised that if he could possess only four of these attributes of the fruit of the Holy Spirit such as long suffering, goodness, gentleness, he would be able to endure difficult challenges. What was particularly striking for him was learning about long suffering, which he referred to as 'endurance'. He said he looked at his situation and decided that he was going to 'endure all things'. This meant that, he was determined to endure all difficulties during treatment like overcoming the withdrawal symptoms, and living with other people, so he that he could overcome drug dependency. He said he also realised he had a long journey ahead of him to recover from drug dependency, and needed to endure. Moreover, he said he did not want to go back to drug dependency and to the streets and wanted to become a child of God. He said that having been equipped with the knowledge of the fruit of the Spirit, he was able to go through the treatment for six months:

> ‘That is the word that make me to survive the, to survive in the camp for that period of six months and still to this present time.’ (Dathan: 45 years, sustained sobriety group)

Second, Mushi claimed that he came to the realisation that he could recover from drug dependency after the teachings received during treatment. He said he compared himself with others who had died in drug dependency, and claimed that being alive gave him hope that God would enable him to recover from dependent drug use. Coming from a polygamous family, he said it would be shameful to die in drug dependency. The quote from his interview transcript further illustrates the role of cognitive re-orientation in recovery:

> **‘**According to what they taught us, as they are teaching us the word of God, so I believe that it is not too late for me.’ (Mushi: 45 years, sustained sobriety group)

Commitment to treatment

Commitment to treatment was important in the process of disengagement from drug dependency. This was shown through positive attitudes such as self-determination and self-discipline. The following examples support this. Daniel said he wanted to be successful and do well. He explained that being the only son of his mother in a polygamous family, the other siblings were watching to see what would become of him. Hence, he wanted to be regarded as someone responsible and successful. He claimed that what helped him most was that he was determined to overcome drug dependency. He said: ‘if a person can think, you understand, and determine to

achieve a thing, he can.' Another informant, Elijah, suggested that he was determined to overcome drug dependency because he had used lots of drugs and wanted to stop. According to him:

> 'I was determined because I have used lots of drugs. So not to go back again, I was determined to get through it and God helped me. I thank God today I was able to sail through' (Elijah: 53 years, sustained sobriety group)

On self-discipline, David, claimed that he realised that lack of self-discipline got him into drug dependency in the first place. Therefore, he embraced self-discipline and it affected his life positively and enabled him to disengage from drugs. Theophilus also explained that through self-discipline he was able to adjust to the new lifestyle in the rehabilitation centre such as waking up early for the morning devotions, and doing his duties. Consequently, he was able to complete treatment and this helped him attain sobriety and a changed lifestyle, which are essentials in achieving recovery from dependent drug use as illustrated:

> 'And also some one of the thing that help me most is my, is my self-discipline.' (Theophilus: 43 years, sustained sobriety group)

Positive self-talk

Positive self-talk was also important. The strategy was adopted by some service users to stop cravings, and negative thoughts. Joana, claimed that she counteracted cravings and negative thoughts by saying positive things to

herself:

> 'I tell myself positive things. I see myself and I'm like; this is who you are now, this is who you should be, prepare yourself girl, there is a difference.... Thoughts keep coming, I wake up with it, I can put things down, I don't mind, I can't afford to let it go. So I tell myself, it's not possible; you can't get me, you can't get me, that is what I always say. You can't get me and I just clear myself out and I back it up with prayers most times.' (Joanna; 22 years old, in-treatment)

5.3.2 Socio-environmental factors

Findings suggest that the main socio-environmental strategies for recovery were support from significant others and peers, acquiring a new identity, confinement and a comfortable environment.

Support from significant others and peers

Support from significant others such as role models, agency staff and peers played an important role in facilitating recovery during the process of disengagement from drugs. Support received from significant others such as role models (former service users who had become staff of the agency), helped them to overcome the challenges experienced during treatment such as; withdrawal symptoms, cravings, uncomfortable relationships, confinement to one environment and ambivalence. These included counselling and role modelling, which provided a source of

inspiration. The experience of Silas, an informant in treatment illustrates this finding:

> 'Well through the prayers and the teachings, especially the prayers and counselling from the care staffs here, telling me their own experience too, so they were encouraging me that if they could go through it I could go through it.' (Silas: 27 years, in-treatment group)

Support received from counselling staff helped in dealing with the challenges of confinement and ambivalence. The experience of Joana, an informant in the in-treatment group, provides a good example. She had spent two months in a hospital before she came to the treatment centre. During this time, she had stopped using drugs. However, she said she craved the drugs so much that even though she didn't want to resume using drugs, she decided she would start again. Besides, she was not happy and was offended that after two months of confinement at the hospital, she was going to go through an extended period of confinement at the agency's treatment centre; hence, she made up her mind that she would not go through with the treatment. However, she claimed that the counselling session with the sector coordinator (counselling), had a profound effect on her and so she stayed on and completed treatment:

> 'But by the second day, I had counselling with the counsellor. I came in today, the next day I was counselled with the counselling coordinator. He spoke to me with warmth… And I was like what? What is going on? I felt something; I knew something was going to change...' (Joana: 22 years, in-treatment group)

Findings also showed that support from peers facilitated recovery. For example, one informant, Elizabeth, explained that whenever she had the urge to smoke cigarettes, she shared the challenge with fellow service users. Similarly, others also would share their challenges with her. Whenever this happened, they prayed together and encouraged each other. She explained:

> 'That was the way I handled it; I try not to think about it, then I will pray over it and I discussed it with other people and I was encouraged not to think about it. That was how I was able to get over it.' (Elizabeth: 49 years, sustained sobriety)

Acquiring a new identity

Acquiring a Christian identity was also important in the recovery process during the process of disengagement. Five informants claimed that the lectures and Bible reviews revealed to them the identity of a Christian. Phrases such as 'a new man', 'a new creation', 'a child of God', 'a chosen generation', 'princess in God' were used in expressing their new identity. Being able to conceive a new identity helped them to discard their old values and embrace a new lifestyle. For example, one informant, Kenneth, suggested that he experienced change, when he learned from the Bible that he was a new man. He said he realised that if he was a new man, he had to put aside his old ways and embrace a new way of life. He said doing this helped him to stop depending on drugs and live a new lifestyle:

> ‘I’m now a changed man because of the word of God because there are so many scriptures in the Bible that tells me I am a new man, I’m a chosen generation…If one will be a new man, then you have to go out of your old ways and embrace God, and if you want to embrace God, you need to go extra mile with God, and going extra mile with God, then you have to leave everything that is not of God. Through that means, I begin to live a new life again.’ (Kenneth: 51 years, recovered)

Confinement

Four informants claimed that being confined to one environment helped them to stop using drugs. They said that by being confined, they had no access to drugs and were also separated from influence of drug-dependent friends. Evidence for this finding is illustrated in the quote by Mushi in the next discussion below.

Comfortable Residential Environment and Resources

Four informants suggested that the residence was comfortable and facilitated recovery. Some service users claimed that the environment made it possible for them to relax and sleep well. This is particularly important during the first week of treatment. In addition, the informants said that their personal needs were met. These included food, clothes, toiletries, and availability of water to take frequent baths which many allege was a form of therapy. For example, four informants claimed that frequent bathing helped them to alleviate the withdrawal symptoms such as body

pains, itching, high body temperature and weakness, which they experienced during the first week of admission. This involved taking several baths a day, since they often felt inconvenienced. Though most said they showered between five to 10 times daily, one informant claimed he took baths up to 20 times a day to be relieved of withdrawal pains. They also suggested that frequent bathing also helped to facilitate good sleep. Moreover, they claimed that they preferred to take frequent baths than access pharmacological treatment for relief from withdrawal symptoms. One informant suggested that some informants who dropped off treatment during the first week of detoxification were those who did not take the bath therapy and left because they were weak. The quote below illustrates the benefit of this strategy:

> 'Em, when you baf, you get your body but if you doesn't baf, you will not have your body.' (Omri: 50 years, recovered)

The findings described above suggest that having no access to drugs, and a comfortable environment, enabled service users to focus on the treatment programme and stop using drugs. The importance of this factor is revealed in the quote below:

> 'But in this place there is nothing like that, you cannot get opportunity to take cigarette, so it help me a lot. And also in this place, they turn to my situation, they give us toiletries, they give us food, we bath very well, because in this place is convenient, its o.k. for us, this place is o.k. for us, we have a lot of water, we sleep, we are free in this place. So, I think that one is o.k. for me. (Mushi: 45, years, sustained sobriety group)

5.3.3 Spiritual factors for recovery

Furthermore, findings revealed that the main elements in the spiritual process of recovery were salvation, prayer, and the training programme. This was backed up by findings from interviews with practitioners in the agency. I need to emphasise here that these spiritual factors are not mutually exclusive, as this study shows. It follows then that one cannot study one process without studying the others: therefore, it seems a comprehensive process. Since it is needful to understand how each of these processes facilitates recovery from dependent drug use, I will present in this section analysis of how each of these strategies played a role in recovery from drug dependency

Salvation

Experiences of 13 informants showed that salvation was transformative and an important aspect of their recovery process. This was described in three ways: an experience of receiving God into a person's life as Lord and personal saviour or being born-again, submission to God, and God taking control of a person's life. Each of these experiences would be described by using examples of the personal experiences of some informants.

Abathiar's experience is illustrative of the experience of receiving God into a person's life. He was dependent on drugs for about 31 years. During this time, he funded the habit by lying and stealing and also lived in the joint in

dangerous conditions. Due to his dependent lifestyle, he was separated from his wife and children. When he got to the point where he became tired of the dependent lifestyle, he felt sorry about this condition and sometimes considered how long he could go on. At this point, he came across the evangelism group from R.C.C.G, Jesus Sanctuary Surulere. Through this group, he said he received salvation, and his life changed totally:

> 'I will never think of going back in my life because God has done a greater thing in my life, a new thing in my life, the day I received Jesus, my life was changed totally. Because when I begin to study the word of God, I have to discover myself. In the book of John chapter 14 verse 6, he says I am the way and the truth, he says no man can come unto me but by me. From there I have to decide to serve Jesus. Because I don't look for another way again, when Jesus has already promised me say I am the way. What I'm I looking for? From there I have to stop. I begin to follow God; I follow the principles of God. That is what is help me right now, he make me to stand. Only Jesus can do it. Only Jesus can do it.' (Abathiar: 50 years, sustained sobriety)

What this finding suggests is that when he received Jesus into his life, he gave up his past drug-dependent lifestyle. He spoke of his experience as better, and as a new thing. He spoke about embracing a new lifestyle, through practices such as studying the word of God from the Bible scriptures, service to God and following God and His principles by means of instructions in the Bible.

Moreover, he attributed his recovery from drug dependence to the changes in his lifestyle, which are evidences of the experience of salvation. He acknowledged that he could only have been saved by the intervention of Jesus Christ. To confirm his new status, at the time of fieldwork, Abathiar was a care-staff in a Christian faith-based drug rehabilitation centre. This experience of salvation was transformative; it suggests that when Abathiar received salvation, he experienced a change in lifestyle and stopped using drugs. Similarly, another informant, Mary, describes her experience of salvation as accepting God into her life. Mary was from a comfortable literate home and was lured into leaving home by her friends. She became dependent on cocaine and ended up living in the joint. She tried to stop using drugs without success. As she considered how to solve the problem of drug dependency, a solution came through the evangelism group of the R.C.C.G, Jesus sanctuary. She said that they told her about Jesus and she accepted Jesus into her life. Mary explained that this means repentance and accepting Christ as Lord and personal saviour. She described repentance as turning away from a person's old ways. She believed Jesus died to pay the price for sin to save a person. She asserted that a person, who receives Him, receives life. She said that by receiving Jesus as Lord and personal saviour, she received life and it helped her recover from dependent drug use, by turning away from drugs and to God. She said:

> 'I don't want to be dead and that's why I receive Jesus as my Lord and personal saviour because I know what I am receiving, I'm receiving life he is the light the truth and the way whosoever believes in him should not

perish but have everlasting life that's what my Bible told me.' (Mary: 28 years, in-treatment)

This experience means several things. First there was an acknowledgement that the past life would lead to death. There was recognition of a solution, by accepting Jesus as a personal saviour, which she did. There was an understanding in the person of Christ as saviour and an experiential knowledge of him as 'life'. Therefore, Mary understood salvation as deliverance and receiving a new life and this helped her to turn away from drug dependency.

Furthermore, some informants described their experience as submission or surrender of a person's life to God. Surrender implies giving something up for another. The experience of Michael an informant in treatment provides evidence for this finding. Michael was a university graduate and dependent on drugs for 20 years. He claimed that it was during the training programme at the agency that he realised the need for salvation. He said he received understanding about God being the source of wisdom, giver of all good things, and true. He suggested that he believed in God's ability to change a person's life. He said he surrendered his life to God because he wanted a new beginning and to be transformed. Besides, he said, through surrender, he had a chance to start life over again. Moreover, he revealed that besides the need for a change from dependent lifestyle, he surrendered to God because he believed that he would give an account of his life to God. This means that he felt the need to

live right because he felt he would account for his life in what Christians believe to be the day of judgement, an event beyond this life (Gunton 2002).

> '…I surrendered genuinely for God to start a new beginning in me. So I saw a need to be rehabilitated because I know it is em the master's you know the master's, the potter's house where I can be remold because I was cracked because of my attitude now I have been mended being given a second chance to take life to be very serious because I would definitely give an account of the life I have been living.' (Michael: 47 years, in-treatment)

The experience of surrender here suggests not only giving up the self to God but also a surrender of self-will. This is expressed figuratively by saying he desired to be re-moulded by the potter that is God, as implied in the Bible in Jeremiah 18. Furthermore, some informants said they surrendered their lives to God to enable them live godly lives, to have the privilege of eternal life, and see God. Therefore, the experience of surrender expressed by informants implies dependence on God and not through the self, to actualise change from drug dependency. For example, one informant, Peter, claimed that after he surrendered to God, he was no longer the owner of himself, and he stopped doing things that are not in line with the teachings of Jesus Christ. As a result, he said he received freedom from the bondage of drug dependency and became a new creature and his drug-dependent lifestyle became something of the past.

The experience of salvation, which was described as 'God taking control of a person's life' is further analysed. Other expressions used were; 'a divine act of God', and 'enablement to live according to Godly principles'. The experience of Onesiphorus, an informant in the sustained sobriety group, illustrates this experience. He claimed that he had been dependent on drugs for 12 years and received medical treatment several times through the support of his brothers who encouraged him to quit depending on drugs without success. He said he succeeded in quitting drug dependency when God took control of his life and he received salvation during the period of treatment at the agency. He claimed that through the lectures, he received understanding about God, and how to walk in obedience and he said God entered his heart, God took control over his life, and he received salvation. He also said he was relieved from the withdrawal pains without using pain relievers such as 'panadol and alabukun'. He further asserted that he has stopped visiting the drug joints abstained from using all drugs. In addition, he explained that when God touched his heart, he submitted to God and walked in obedience.

> 'Mo wa wa si Wellspring Rehabilitation Centre, ibe ni mo ti ri igbala, ti won ti bami soro Olorun, to tun fi gbogbo itumo kiniyen han mi wipe a gbodo ma disobey. Disobedient, orisirisi lecture, to fun wa, won de ton fun wa ni oro olorun ni iseju iseju, ati be, emi na de ri pe Olorun gbakoso, Olorun ko si mi ninu lai lo ogun Kankan, koda alo panadol, koda alo alabukun. Oro Olorun yi nikan lo ko so funwa, to fun way ni iseju iseju. Oro Olorun yi, yen nikan, lo de kosi mi ninu, titi titi titi di ojo teni. Mi de gbono joint mo, mi mu drugs mo, mi mu oti mo, mi mu ciga

> mo, mi mu igbo mo. Emi na wa ripe Olorun, oro Olorun wa ko si mi lokan, mo wa tun ri igala nibe.'
>
> ('God made a way for me to come to Wellspring Rehabilitation Centre. It is there I received salvation as I was being talked to about God, and as they were giving me an understanding of those things that we should not be disobedient, all sorts of lecture that we were given. They also gave us the word of God, second by second. From there, I realised that God took control, God entered into me, without using drugs, infact without using panadol, we did not use Alabukun, we were being given and talked to about the word of God second by second, and the word of God, entered into me till today. I do not go to the joints again, and I do not take drugs again, I do not take alcohol or cigarette again, I do not take Indian hemp again. I realised the God, the word of God now entered my mind and I also received salvation.' (Onesiphorus: 56, sustained sobriety)

In this case, the experience of salvation was described as a divine act of God. It suggests that God himself touched his heart and delivered him from drug dependency.

The accounts of service users described above were supported by one of members of staff who teaches the course on salvation, in interview. An interview with a senior Pastor who teaches the course on salvation, suggested that the aim of the course is to provide understanding that a person can be free from drug dependency through salvation. He said that drug dependency is a spiritual problem, because it breaks down a person's ability to obey God. He defined sin as a breach of God's law, or an

outright rebellion against God's law. He said because drug dependency is overpowering, it is difficult to come out of drugs until a person becomes 'spiritually regenerated'. In addition, he explained that through the process of salvation, (a three-fold process of repentance, redemption and sanctification) a person is freed from dependent drug use. He clarifies:

> 'But this repentance we're talking about is not just resolution. It is deep sorrow for sin and turning away from sin and letting God know I have realised where I was wrong, I was trying to run my own life, but now I am turning my life over to you. I am now changing the steering from, I'm I'm I'm turning over the wheel to you I will not be the one behind the wheel anymore, You will be the one behind the wheel. This is repentance. And trusting God from that moment on that each day I will live a life that is above sin.' (Facilitator, W.R.C.)

The pastor, further explained that as an intervention, repentance is achieved by encouraging service users to confess their sins and ask God for mercy, based on the scripture verse in Proverbs 28:13 which says: 'he that confesses his sin shall obtain mercy'. This also means promising God that they will never go back to sin. Speaking on the role of redemption in salvation, he defined redemption as the understanding that Jesus Christ became a substitution sacrifice for sin; when a drug-dependent person realises that the price for sin is already paid and has already been set free, he becomes free from the overpowering nature of sin and drug dependency. On the role of sanctification in salvation, he defined sanctification as separation for moral defilement to divine use by the divine enablement of God. This act he said is God's divine surgery, to remove the negatives from a person's life which brings about a

change of heart. He based his argument on Ezekiel 36:25. He maintained that the process involves a desire for holy living and praying effectively to destroy the power of inbred sin. He suggested that the result of sanctification is that the person who is saved grows in grace, becomes spiritually mature, develops distaste for old habits and possesses the ability to live above sin. As a treatment intervention, he claimed that during the course, he always asked the service users to reflect on their lives to enable them to realize the impact of drugs and the need for a change from dependent drug use.

During my fieldwork, I observed the admission process of the new intakes and was able to see first-hand that potential clients were given the opportunity to receive salvation, and they accepted the offer of salvation through Jesus Christ as the basis of their walk with God. Interviews with informants showed that it was through the teachings that some service users saw the need for salvation and experienced salvation. This was described by informants in terms such as the knowledge that commitment to God brings about transformations and success in life, God as the author of wisdom, knowledge about the person of God, like finding out that God is dependable, and the promise of a future life with God. From these understandings received, some informants felt they had been able to release the control of their lives to God. Michael's account illustrates this:

> 'So since the Bible clearly spells it out that wisdom is gathered from God because he is the giver of every good thing and the fear of God is the beginning of wisdom so I had to allow the teachings here to give me

more insights and in-depth knowledge about God so and I understand now that God has never lied so all his promises are there for anyone to claim and receive it and apply it so I surrendered genuinely for God to start a new beginning in me.'(Michael: 47 years, in-treatment)

Prayers

The experiences of informants revealed that two types of prayers facilitated recovery from dependent drug use: the deliverance and personal prayers. Therefore, the findings in this section will be discussed under two themes: the role of deliverance prayers and the role of personal prayers in recovery from dependent drug use.

Deliverance prayers

10 informants claimed that deliverance prayers were instrumental to their recovery. These will be discussed under three themes: meanings attached to deliverance prayers, ways of engaging deliverance prayers to facilitate recovery, and the effects of deliverance prayers on recovery. In terms of the meanings attached to deliverance prayers, findings revealed that some informants conceived deliverance prayer as a means through which they could be free from drug dependency and receive healing from withdrawal symptoms. Many informants expressed the views that they had found it impossible to stop using drugs, after trying out several treatment methods, including medical and traditional treatments. They believed that drug dependency was a bondage that they could not overcome on their own. Therefore, informants

viewed deliverance prayers as an instrument of power which was effective to overcome drug dependency. Moreover, they suggest that through this means, they were delivered from the bondage of drug dependency. The quote below explains this:

> ‘But during our first week of coming into this place we go through em the deliverance service; I could say it is through that period in time that the power of God touched me and break away the yolk of Indian hemp and cocaine and drugs from my life. ‘(Theophilus: 43 years, and sustained sobriety)

Furthermore, findings revealed that deliverance prayer was done in several ways by crying to God for help, calling on the names of God in prayer, making decrees or pronouncements and using Bible scriptures in prayers. The first type of deliverance is suggestive of a state of helplessness and a dire need for help. Besides, it is indicative of belief in the power of God to free them from drug dependency and a reliance on God alone for help by looking up to him. Omri, explained how the name of God was used in prayers. He said that the deliverance minister called on the name of Jesus to break covenants and nullify negative powers and they responded by saying Amen. Regarding making decrees in prayers, Abathiar, said that during the one week of deliverance prayers, service users were asked to make pronouncements and he was set free and regained self-regulatory control, as stated below:

> ‘That prayer, that anyone, who enemy gather, written your name, drop it at the shrine, God will destroy it. That is the most important prayer which

> helped me to live in Adullam and God set me free and I begin to see by myself.' (Abathiar: 50 years, sustained sobriety)

In addition, Omri, cited Jeremiah 18 to explain how scriptures were used in deliverance prayers. This scripture referred to God figuratively as the potter that moulds the clay (referring to human beings). Omri explained that based on this scripture, the deliverance minister led them to pray that God should remove the negatives from their lives and re-mould them. He said through the prayers, he recovered from drug dependency:

> 'We are praying to God; the man told us about em Jeremiah 18; he told us that we should go and focus on that portion. That we come to a porter's house: according to his prayers, he will say; we don come here now, baba, all the place wey we hiding ourselves, help us to remould everything, and by God's grace, everything become normal.' (Omri: 50 years, sustained sobriety)

The evidence above suggests that deliverance prayers were important tools for disengaging from drugs. It also reveals that using Bible scriptures in prayers was transformative and shows the role of faith in recovery.

In addition to these narratives, Interviews with staff of the agency revealed that the aims of the deliverance prayers include breaking off controlling evil spirits and spiritual connections associated with drug dependency, with a view to helping

service users achieve abstinence from all drugs and facilitate healing from the effects of withdrawal symptoms. One member of staff suggested that deliverance is the act of expelling stronger spirits that subject people to drug dependency, thereby giving them the ability to regain their will power. In an interview with the minister who conducts the deliverance prayer sessions during the first week of admission, he added that one of the aims of the deliverance prayers is to break off covenants that informants have had with drug sellers or malevolent forces that keep dependent drug users bound to drug dependency. This point has already been discussed in chapter four, in relation to service user's accounts. They suggested that the influence of evil spiritual forces manifested in many ways like the inability to stop using drugs, hearing of voices, and negative dream experiences that compelled them to use drugs whenever they attempted to quit drug dependency. Deliverance prayers were conducted by praying in the name of Jesus, through the enablement of the Holy Spirit and the application of the word of God in prayers.

Personal prayers

11 informants claimed that the practice of prayer as a personal lifestyle and as an intervention also played a significant role in their recovery. It is interesting to note that personal praying helped nine persons who did not experience instant extinguishing of cravings from deliverance prayers described in the preceding sub-section. The nine persons were not among those who responded as having benefited from the deliverance prayers. These persons explained that they struggled with overcoming cravings from drugs, which for some, occurred for some months during treatment. Furthermore, some informants prayed to counteract bad dreams (described

in section 4.3.3.), and healing, especially against negative affective states. In addition, a female informant suggested that she often prayed whenever she had the desire to leave.

Prayers were used in many ways. First, this was done by speaking against the negative condition that was experienced. For example, to nullify cravings, the quote below is illustrative:

> 'Every negative thought, every negative thinking, let it be uprooted, let it be destroyed out of my life in Jesus name.' (Balak: 52, sustained sobriety)

In addition, the evidence below is an illustration of how negative spiritual influences in dreams are counteracted:

> 'As I want to put am inside the bottle we use to smoke it, I want say I will smoke it like this, ah! I will say, I will just rise up from where I slept ah! I say no! I rebuke you, I will not go back smoking again I be praying, praying, praying, praying, praying, that is how my heart remove from that drug.' (Dathan: 45 years, sustained sobriety)

Other types of prayers engaged during treatment to nullify cravings were scripture praying and prayers of supplication for mercy and grace. These were engaged in similar ways as those previously discussed. Findings also revealed that people prayed

at various times, from night prayers to being in a constant state of prayer. Prayer tools utilised were fasting, faith and an earnest desire for a change. Findings also indicated that the benefits of personal prayers include the ability to manage cravings, extinguishing cravings, removal of negative thoughts, abstinence from drugs and healing from withdrawal symptoms.

Training in Biblical principles and Bible study/ meditation

The findings revealed that the training received through Bible based courses, Bible study and meditation facilitated recovery in two main ways: first, the courses provided knowledge on various aspects of life and such knowledge gained produced positive behaviour that facilitated recovery. Second, the impact of hearing of the word of God removed the desire for drugs, produced negative affective feelings and physical healing. These factors ultimately resulted in change from a drug-dependent lifestyle.

Turning to behavioural changes, 19 informants suggested that the enlightenment provided by courses such as theology, purpose and pursuits, goal setting, and backsliding, and the Bible scriptures, produced a change of heart from old lifestyles. They provided motivation to live a better life, guidance for life, knowledge of God, produced faith, gave a new lease of life and a Christian character; these consequently brought about behavioural changes. Benjamin's experience provides an illustration. Benjamin was a 52 year old informant and drug dependent for 30 years. He suggested that what enabled him to recover was continuous renewal in his mind of

the Bible scriptures, which helped him to change his thinking, and turnaround from a drug-dependent lifestyle.

> ‘But, when I came to Wellspring, during the Bible review, see…I’m made to understand that, with Christ all things are possible. So I start trying to…renew my mind towards the words of God, day in day out, day in day out like that, my mind was completely off the drug, I don’t even think about drugs again. And there are lots of people in the Bible that makes me really want to change. People like Jabez, when I hear the ehh…after hearing and reading their stories, if God can do it for these people that means God can do mine too. So I started praying, believing in God that someday, somehow, he will turn my life around. Before I left, under three months I started noticing new things in me. My way of reasoning those eehh…street games I used to play, I, I now look at it as if I have committed big time time sin. So I started asking for forgiveness. I didn’t know. I thought it was just pranks, street games like that. I never knew that I was sinning against God and humanity. So I beg God for forgiveness and imm...i try as much as possible to put those things behind me and continue with life.’ (Benjamin: 52 years, sustained sobriety)

Regarding removal of desire for drugs, negative affective states and physical healing, seven informants claimed that through the teachings, desire for drugs was removed, negative affective states were dealt with and healing experienced. This was experienced through hearing the word of God, reading, studying, meditating, obeying the instructions and using it as a tool in prayer. Consequently, they were able to

regain self-regulatory control, experience inward changes such as emotional healing, faith, nourishment, joy, peace, and hope of a better future. For example, an informant in the recovered group, Elizabeth, was dependent on nicotine for 18 years and prescription drugs for 11 years. She said that during the period in drug dependency she was unforgiving towards people who had rejected and abused her. She explained that through the teachings she was convinced of the need to forgive those who had hurt her. She claimed that being able to release feelings of un-forgiveness caused her to blossom with a new life. She also said she was convicted of wrongs against God and family members, as a result of the drug-dependent lifestyle. She said through the nourishment she received from the word of God she received grace to forgive those who had offended her. Being able to let go of the past in turn brought about a new lease of life, taught her how to be happy and helped her to give up nicotine dependency. Her experience is stated below:

> 'But the most important thing there is the word of God; that is what nourished me, that is what set my soul free and that was what delivered me from the bondage of drugs and this un-forgiveness I was talking about and that is what gave me another lease of life that made me to know that hey! I have lost a lot but I can still make it again even better than before and that so that is what is really keeping me going.' (Elizabeth: 49 years, sustained sobriety)

These findings agree with the views of some staff of the agency. Speaking on the benefits of the treatment programme, a member of the management team suggests

the effect of the treatment intervention is that service users have a changed lifestyle. This is revealed in the excerpt from his interview:

> 'At the end of this programme, a lot of them are able to imbibe Christian ethics, they are able to stand firm, they are well motivated, I mean, taking up challenges, playing roles and they are ready to acquire a vocation. They are ready to go for vocational training.' (Coordinator W.R.C.-1.)

Another interview was conducted on the word of God, with another course facilitator, to explore how the Bible scriptures (referred to as the word of God), bring about transformation. Three explanations were proffered. First, he suggested that the Word of God brings about the cleansing. Basing his argument on John 15:3 he said Jesus Christ said: 'Now ye are clean through the word which I have spoken to you'. He said though this is a mystery, it has proven to be effective. He explained that the process through which they come to understand the word of God, is that they hear it, (whether they can read it or not), and it is transformative. He suggested that recovery is enabled when service users pay attention to the word of God in their hearts. He said doing this keeps them strong and going. He also suggested that the abstinence oriented programme also assist in facilitating change. Second, he claimed that the word of God is an instructional manual for life and when the instructions were obeyed, (since these are from God), lives were restored. He likened the way it works to the way a DVD manual works. He said when instructions are followed, it works and vice versa. This is revealed below in the excerpt from this interview:

> ‘The word of God is a manual given to every one for the operation of life, so that your life is not spoilt, so that life is lived properly. And so that you end up in your ultimate salvation that we believe in. That is the purpose of the word of God, an instructional manual. That is it.’ (Coordinator W.R.C.-2)

Third, he suggested that the changed lives of ex-service users who have recovered made informants in-treatment want to learn about the word of God and listen. He emphasised that making use of the word of God is important to the recovery process, because is the instrument of restoration. According to him, ‘the word of God is the tool; it is the actual tool that gets the job done.’

On how the word of God removes cravings, he asserted that the origin of craving is the mind, and the Bible’s prescription for this is that we should renew our minds and it is only the word of God that can renew our mind. So he claimed that when service users renewed their minds with the word of God, cravings ceased. In addition he also said the word of God is spirit and life, and this is used to combat negative dream influences. Further, he also suggested that the appropriation of the word of God by faith makes the programme effectual. To explain this he said:

> ‘Someone said that faith is the ability to take things from the spiritual realm and make it manifest in the physical. So this is a faith-based system, what we are doing is using the word of God, and the word of God is what brings about faith, to lay hold of things in the spiritual realm,

which is the affliction of drug addiction dealing with it at that level by the word and make it manifest in the physical as rehabilitation and restoration.' (Coordinator W.R.C.-2)

5.4 Maintenance of recovery

The period of maintenance in recovery, is when the gains of recovery achieved during treatment are consolidated. However, the findings revealed that there were several challenges faced during this period. This section discusses how recovery is sustained under three themes: psychological, socio- environment and spiritual.

5.4.1 Psychological factors

Interviews with informants also showed that self-help actions such as positive self-talk, avoidance of triggers of drug dependency, and adopting alternative lifestyles were factors that helped to sustain abstinence from drugs.

Positive self-talk

Six persons claimed that positive self-talk helped them in their recovery. This action served as a counter condition mechanism, particularly to cravings and negative affective states. The cravings were counteracted by positive self-talk involving speaking and appropriating positive scriptural verses as indicated by Chris or outright positive declarations as claimed by Abraham. The excerpt from Chris' interview is indicative:

‘Me, the Lord is my shepherd, I shall not want.

He maketh me to lie down in, in green pastures,

He leadeth me beside the still waters,

He restoreth my soul.

He leadeth me in the path of righteousness for His name sake.

Yea, thou I walk through the valley of the shadow of death,

I shall fear no evil for thou art with me.

Thy rod and thy staff they comfort me.

Thou prepareth a table before me, in the presence of my enemies.

Thou anointest my head with oil, my cup runneth over.

Surely, goodness and mercy shall follow me all the days of my life,

And I will dwell in the house of the Lord forever, amen.’ (Chris: 51 years, in-treatment group (completed vocational programme during fieldwork)

Furthermore, Abraham’s claims that:

‘Mo ri challenges, mo ri igbo ni ojo jumo. Mo ri gbana, mo ri oti, mo ri gbogbo e. Mo ri challenge gan, but mo ni iro! Mi o ni se nitoripe, last chance ni eleyi. Mi o de ni miss last chance yen.’ (Yoruba language)

(I do experience some challenges; I come across Indian hemp every day. I come across gbana, alcohol and everything. I experience a lot of challenges but I say no! I will not do it that this is my last chance and I

will not miss it.') (Abraham: 41 years, in-treatment group (vocational training)

These accounts suggest that positive self-talk as a counter conditioning strategy was effective in counteracting negative thoughts which often lure people back to dependent drug use after a period of abstinence.

Avoidance of triggers of drug dependency

Another strategy adopted by thirteen informants to maintain sobriety was avoiding drug cues or stimulus when the service users were re-introduced to the society (during the period of vocational training and after graduating from the treatment programme). Challenges experienced include; being exposed to different drug cues like the smell of drugs, places where drugs were being sold (a major cause of relapse in the study), drug using friends and negative emotional states such as anger and negative thoughts and personal concerns. From their experiences, this was achieved by avoiding places where drugs were being sold, avoiding coming into contact with things that could attract them back to drug use, rejecting the desire to use drugs, separation from former associates still in drug dependency, and relocation away from drug using environments. The interview excerpt below provides an illustration:

'And outside I don't even mingle with people that even drink, I don't even mingle with people that smoke, I don't mingle with people that go to the joint…

> Most a times if I even go to visit my pastor, in the office, because my Pastor stay, working around that place, by the time I go, I just go straight to his office and immediately I come out I just take Okada (Motorbike), even for me to take a bus I won't wait, I will take Okada, far away from that place then I will go and get bus. I don't try to mingle with them; that is the only way I try to keep myself off it.' (Kenneth: 51 years, sustained sobriety)

Furthermore, one key finding is that the informants claimed that abstinence from all drugs is very important in recovery from drug dependency as revealed below:

> 'Even cigarette, if they put it down that if you smoke it, I'm going to give you one homer jeep, I will not, I will not taste it, because, cigarette is the assistance of drugs. But, so it's very good for someone to abstain from it. To go away from it totally. That is, from cigarette, from drink, from igbo (cannabis).' (Chris: 51 years, completed treatment)

Adopting alternative non-drug lifestyles

The changes of lifestyle embraced were adopting a Christian lifestyle; positive attitudes; self-development; taking up gainful employment. The findings about the Christian lifestyle will be discussed under the topic, spiritual strategies below. With respect to positive attitudes, the findings relate to the following: determination, facing up to the problem instead of running from it, and hatred for drugs. Some

examples will be used to explain these findings. For example, one informant, Elizabeth, who was dependent on nicotine and prescription drugs, suggested that before she left the treatment centre, she was determined not to smoke again. But when she returned home, the urge to smoke returned. She maintained her resolve not to resume smoking and eventually overcame the cravings:

> 'So when I got home, the urge came so I now cautioned myself that if I try it once, am going to go back so I made up my mind and by the grace of God I did not. But like I said earlier, sometimes I will just chew chewing gum, but now it doesn't happen to me anymore. Thank you.' (Elizabeth: 49 years, sustained recovery)

Another new lifestyle adopted was self-development. Since most of the informants were not in gainful employment during the time in drug dependency, they went to vocational or academic institutions to improve themselves. One of the informants Benjamin, asserted that it was a great experience for him. He said:

> 'Really since I left Gilgal because from Gilgal straight to the Bible College, where I spent two years at Enugu Bible College, it's been great. Because it's like searching for more knowledge, more truth about the word of God. And that has helped me a lot.'(Benjamin: 52 years, sustained sobriety)

In addition, positive attitudes such as determination not to use drugs again, facing up to the problem and hatred for drugs helped some informants to stay drug free. Finally, all informants in the sustained sobriety group claimed that

they were in gainful employment.

5.4.2 Socio-environmental factors

The main finding was that supportive relationships helped informants to sustain recovery.

Findings revealed that the network of support established were from the church, work, non-drug-dependent friends, facilitators of the programme and family. The support received helped them to sustain sobriety. The most important support identified was support from family. This is significant because most of the informants had severed ties with their families when they were dependent on drugs. During treatment, they re-established ties with their families. This proved to be very helpful because after treatment, most of them had to return to their families. Most informants claimed that when they returned home after treatment, their families welcomed them back warmly. For example, one informant, Onesiphorus, said that he was given accommodation in the family house and given employment as a supervisor in the family owned transport business. According to him, his family did not reject him and he was happy with the support he always received from them. Another informant, Omri, asserted that his family was willing to support his plans to build a new future for himself and held him in high esteem. His family's support was very meaningful to him because he said he had been rejected by them and he expressed joy when he talked about this:

> ‘The difference in my lifestyle now e be like I am just a baby born pikin (Child) because I was rejected for my family and my family now, are looking for me seriously. I be like a king for my family. And my family want to assist me in anything that I say this is the way.’ (Omri:50 years, sustained sobriety)

Furthermore, interviews with some family members on the role they played revealed that during the vocational training, they prayed for them, visited their wards and encouraged them, supported them financially, and after graduation received them back home. Two examples will be cited; one from an informant’s father and another, an informant’s wife. First the father of an informant asserted that:

> ‘Em as I said earlier we supported him with our prayer, we welcomed him back into our home, and em we have discussions with him whenever the opportunity affords us to do so. We made him to know that he is still our son; we are willing to help him and we made him to know that. Although he disappointed us but we em put that in the past and we are looking forward to the future. We’ve supported him we are clothing him we are giving him monthly allowance, and we are visiting him em, as often as possible. We get in touch with him on the telephone once or twice a week regularly and we continue to do this and we make funds available for him to be able to get in touch with us like telephone or any other thing.’ (Mr Josiah: family)

Second, the support of one of the informant’s wife is presented below:

> ‘When I have money I use to give him, if it is five hundred I will give him, I will say let him use it to hold hand so that he will not go and join with them, if I see him I say Chris this way you are moving oh I don’t like it….’ (Beauty: family)

This evidence sheds light on the role of the family and significant persons in recovery. It suggests that persons who have come out from treatment need love and support, to strengthen their resolve to go on in their recovery.

5.4.3 Spiritual strategies factors

The findings have been categorised into three: adopting a Christian lifestyle, prayer, and empowerment by the Holy Spirit.

Adopting a Christian lifestyle

The findings relate to daily reading of the Bible for spiritual nourishment, memorising the scriptures, keeping personal devotional time, attending services in the church like Bible studies and faith clinics, regular praying, in particular when they are tempted to use drugs, practicing the word of God, applying the word of God in situations when there is a temptation to use drugs, abiding by the principles of the word of God for Christian growth, focusing on the word of God, and submission to God. The informants also suggested that the practice of the Christian walk, helped them to grow spiritually, this in turn helped them to resist going back to drug dependence whenever there was a temptation to do so. I will here draw on two

examples: the first example illustrates how negative thoughts were counteracted with the knowledge of the word of God, gained during the time of personal devotion:

> ‘There was a day I was coming along the way, and I have almost about em N10,000 with me and the urge just come into me that ah! Theophilus why not, if it just once, nobody will see you. Why not just take this money and just go and just do it for once then you brush your teeth you use this, the urge was so much that I just find myself standing in one position that the, the pressure, I don’t know what to call it. Is it a pressure or what? It was so much on me that I just stood there and I look up, I said God I don’t want to go I want you to help me. Then I hear because that morning what I study was the word where God was telling Abraham that I am your portion and your exceedingly great reward then that word just came to me that haven’t I told you this morning that I am your portion and your exceeding reward? Then, immediately that I received that thought, the, the, thought to go and smoke just loosed up immediately. I just feel a great relief within me.’ (Theophilus: 43 years, sustained sobriety)

The second example illustrates how an informant drew on the knowledge gained from the Bible to resist pressure from his friends to resume drug consumption:

> ‘By the time that I am going for this vocational training, I have seen many temptations. Some of my gang wey we are working together snatching (cars), are coming to confuse me, tell me that how many years that I can wait like this for; me wey I am counting money, I am waiting

> say God will do it? I snubbed them; I said go away behind me. I remember some scriptures that they give us in discipleship training like 1 Peter 5:8; James 4:17, many like that. I used this to confront them, to tell them that I am now a born again Christian that I focus in Jesus Christ. I will not go back to my vomit again, because I am going forward.' (Omri: 50 years, sustained sobriety)

This evidence shows that the Christian lifestyle was important for maintenance of recovery. It also shows that they possessed personal resources, in this case the knowledge of Bible scriptures, which they were able to draw on to resist temptations to return to drug dependency.

Prayers

Findings suggest that prayers were used to counteract the effect of cravings, negative thoughts and negative dreams relating to drug consumption. One informant, Chris, suggested that he experienced negative dreams relating to drug consumption. He said that he would dream that he was being given drugs in his dreams or hear his name being called. He associated such dreams as one of the causes of relapse and believed a person must stand against these influences through determination, faith and prayers; otherwise, it may result in relapse.

> 'So at times when we used to dream, I mean sleep, you dream when dealer will come with chunk, with market, he started giving us. But when I struggle in the dream I don't want, o.k. you don't want hen and you dey

come inside this place. It will seems I'm inside the joint. So they will say; o.k. if you no dey inside, oya oya commot. Something wey never used to happen before. Dealer no used to dash us (This means give us) market. Just some other joints I used to hear it. Through the story they, our friends used to give us here that their dealers used to dash them market. So the thinking will just put it into a dream. …….

As he is dreaming it or as he is, sometimes as you are sleeping, it will seems they are calling your name: come! They will be calling your name. Higher voices far away in the spiritual realm. This kind of thing can make somebody, if somebody does not devote himself into Christ, or if somebody does not even have that faith, the person, just go back unless the person has already determined.' (Chris: 51 years, completed treatment)

In terms of cravings, informants in the second stage of treatment, and four informants in the sustained sobriety group claimed that they still craved drugs. The spiritual strategy used in counteracting this was prayer. The ways they prayed were: rebuking the condition, rebuking the devil, making positive confessions and scripture praying. Phoebe's experience is illustrative:

'And sometimes too, the urge come to me it will be telling me go, go, go, but I always tell him devil you cannot use me again; since you were using me what have you give to me all that you gave to me you have

taken it, them back again you naked me so since I have been serving you I didn't see any gain I didn't have any gain from you so you can use me anymore. Sometimes I will be talking I will say you cannot use me anymore, you can't. If a day that thing will not come the urge will come it will always come mostly when somebody make you angry or sometime maybe you need something may be you need money to do something and you do not have it you will be thinking many, many things what can I do? Abi I should go back? Many thought will come to you but is, is God, it is only God. When you believe in God that you are serving and I tell him me I don't want to be useless in life I know that the remaining life that remain for me that's what I always think I can still use it much better.' (Phoebe: 45 years, sustained sobriety).

This evidence represents an example of informants using different kinds of prayer strategies to counteract the cravings experienced. This evidence also showed that for some persons, cravings present a challenge to stable recovery and the effects need to be counteracted. It also showed that possessing personal capital is essential in breaking away from drugs but also in consolidating the gains or remaining abstinent.

Empowerment by the Holy Spirit

The findings also suggest that informants experienced a divine ability that helped them to resist drugs and drug using friends, maintain their new drug free status and

practice the Christian faith. This divine enablement was described as empowerment by the Holy Spirit.

> 'I want to tell us, it is the Holy Spirit that empowers me because I am somebody that enjoys the association of friends in the past. But now how I can only stay with my wife and every day read the Bible? When I say read the Bible, without the help of the Holy Spirit you are not able to read the Bible oh because it is not easy since it is not a newspaper or it is not a story book per say though you enjoy it. It is the Holy Spirit that makes you to enjoy reading the Bible and when you continue review it; you want to read more, so this is what I mean. It is the Holy Spirit that empowers us; it is the Holy Spirit that empowers me.' (Elijah: 53 years, sustained sobriety)

The word of God

Some informants also suggested that the word of God played an important role in enabling them stay off drugs. One informant, Elijah, suggested that he commits the scriptures to memory and often recited them whenever he had a temptation to use drugs. Scripture praying was common to most of the informants and this has been discussed under prayer. Findings also showed that obeying the instructions of the Bible also kept them away from drugs.

> 'And with this memory verse, I think I was able to memorise some scriptures that whenever I want to have attack, then I would try to recite and when I remember I begin to meditate on this memory verses and I

began to get meanings and from these, when the word began to make meaning unto me.' (Elijah: 49 years, sustained sobriety)

5.5 Summary of findings

The process of recovery was discussed under three main themes, representing the major stages of recovery identified in literature: motivation, disengagement from drugs and maintenance of recovery. Findings showed that there were several factors that motivated recovery from drug dependence: psychological, socio-environmental and spiritual. The psychological factors were two-fold. First, when informants reached a point when they were tired of their drug using lifestyle, they lost the desire for continued dependence on drugs and the associated lifestyle. Although this provided motivation for recovery, however, they were not able to stop using drugs on their own. Second, self re-evaluation was an important factor that motivated the informants to quit the drug-dependent lifestyle. Also, some socio-environmental factors motivated change. The push factors were negative treatment such as verbal abuse, lack of recognition, rejection, inflicted on drug-dependent users by the members of the society, the physical loss of a loved one (which created a vacuum in the person's life), and the negative impacts of dependent drug using lifestyle. The pull factors were changed lives of friends formerly in drug dependency; influence of supportive non-drug relationships such as friends and family members; and the offer of help by the agency. This proved to be the most significant, because it enabled all informants to take a positive step and enrol for treatment.

In addition, the process of disengagement from treatment was explored under three themes: psychological, socio-environmental and spiritual. Psychological factors of change were cognitive re-orientation and commitment to treatment. The socio-environmental factors, were support from significant others such as care-staff who had passed through treatment and recovered and agency staff, especially during the first week of withdrawal from drugs; new Christian identity which enabled them to separate themselves from past lifestyles of drug dependency and embrace a new lifestyle; confinements which facilitated recovery through situational change and separation from drug using environments; and lastly, a comfortable residential environment. There were also spiritual dimensions to recovery. Three factors which contributed to recovery were salvation, which the findings suggest is transformative; prayer, and the training programme. The training includes Bible reading and meditation, that provided nurture for the soul, defence against negative thoughts and facilitated the adoption of a new lifestyle. These responses to treatment suggest that that this model affects every area of functioning positively, restoring the informants' sense of self-worth and self-regulation, proving hope and belief, and promoting self-efficacy.

Furthermore, findings revealed three maintenance strategies. These are positive self-talk, avoidance of triggers of drug dependency, and adopting an alternative lifestyle. With these tools the informants were able to manage the challenges of drug dependence. This evidence, also suggests that the Pentecostal Christian treatment of drug dependence is effective in bringing about recovery from drug dependence. The way these findings relate to literature on recovery will be explored in the next

chapter.

Chapter 6 - Discussion of findings and implications for policy, practice and research

6.1 Introduction

Two main research questions addressed in this study were: What are the conditions of drug dependency? And how do dependent drug users recover from dependent drug use? These two questions informed the discussion in the two findings chapters. They are examined here again, now set in the context of wider research on the topic. The chapter then goes on to consider the implications of the study for policy, practice and research.

6.2 Conditions in drug dependency

Two key issues emerged in the findings: commencement of drug dependency and experiences in drug dependency.

6.2.1 Commencement of drug dependency

The findings suggest that the main factor which brought about drug dependency was socio-environmental, the influence of friends being the most significant. This supports findings from other studies which have offered accounts of the relationship between peer influence and drug consumption. For example, a Swedish cross-

sectional survey data on young individuals aged 12-18 years old by Lundborg (2006), on peer effects in adolescent drug use shows that peer effects were found in binge drinking, smoking and illicit drug use. Another study by Kuntshe and Jordan (2006) on adolescent alcohol and cannabis use in relation to peer and school factors confirms that association with substance-using friends is strongly related to individual substance use in both alcohol and cannabis use. Furthermore, the findings support evidence from the National Drug Law Enforcement Agency, (1997) that peer influence was the greatest predisposing factor to drug use among patients admitted for drug related problems in 20 health institutions across Nigeria. (This accounted for 50% of all cases.) A baseline assessment of drug use across secondary schools in Lagos (Emafo1999) also noted that most informants were introduced to drugs as adolescents.

6.2.2 Experiences in drug dependency

Findings have drawn attention to the reality that drugs use could be both rewarding and problematic, and also resulted in a loss of self-control. Drug consumption was rewarding because it was pleasurable, providing feelings of elation or euphoria, self-worth, physical strength and boldness; the benefits associated with drug consumption made the informants desire to use drugs. At the same time, it made quitting difficult and led to several years of dependency for most of the informants. This seems to provide evidence which supports a rational choice model of behaviour as proposed by Ajzen and Fishbein (1980), who argue that human beings consider the consequences of their actions before engaging in behavior. This suggests that drug-

dependent persons make rational choices in their continued use of drugs; they weigh the benefits and impacts and decide that the immediate benefits outweigh the disadvantages. This may account for early dependence on drugs. However, since informants suggest that they also became tired of their drug use and only continued because they could not help themselves, this theory cannot fully account for the cause of drug dependence in this study. Cognitive theory offers another way of thinking about this suggesting that a person's beliefs and expectations about drugs influence their reaction to drugs (West 2006). Findings from the United Nations International Drug Control Programme (1992) revealed that stimulant drugs such as cocaine give a feeling of mental clarity and muscular strength. Therefore the short-term gratifying effects of a substance, including feelings of enjoyment, provide the reasons for continued dependence on drugs.

There is, nevertheless, another issue here. A central feature in cocaine use (commonly abused by the informants in this study) is intense craving. The informants explained that the pleasurable effects, such as elation and well-being, wore off quickly and the absence of this feeling made the user crave more of the drugs in order to keep experiencing the same effect; this made the informants continuously dependent on the drug. This finding mirrors earlier evidence from the United Nations International Drug Control Programme (1992), that crack cocaine, which is usually consumed to give a quick intense high, 'lasts a few minutes and leaves the user desperate for more'. This has been explained by West (2006), who suggests that frequency of use results in stronger cue-response-reward association. Another important finding is that hallucination was a major reason for multiple drug

use (informants used depressants to resolve the problems caused by stimulants), and in this way, caused more complex problems for themselves.

Another key finding is that drug dependency led to loss of control over drug use and made dependent users spend several years in drug dependency. This is supported by earlier studies which suggest that dependent drug use often leads to loss of self-regulatory control (DiClemente 2003). DiClemente argues that lack of self-regulatory control may lead the user into several years of dependency due to the inability to break off from drug dependency, consignment to drug dependence and, for some, despair. Therefore the challenges that these findings present for dependent drug users and treatment agencies are how to motivate drug-dependent users to stop consuming drugs, extinguish cravings and restore self-regulatory control.

Drug using neighbourhoods locally referred to as 'joints' also contributed to drug dependency by providing easy access to drugs, group cohesion, support, acceptance and shared norms. Put simply, drug users found validation for drug consumption in the joints. The findings agree with Cohen's (1955) early observation that subcultures promote drug dependency in the following ways: first, through shared activities in the joints such as drug consumption. Second, drug dependence is promoted through shared group values and interests, support, and acceptance. An important issue that this finding raises for practitioners is that since drug using neighbourhoods promote drug dependency, how might drug-dependent users be motivated to enrol for treatment?

Arguably, the most important finding in the study is that drug dependency has a spiritual dimension in both the African worldview and Pentecostal Christian perspectives. In the African worldview, some informants in the study claimed that drug dependency was influenced by malevolent forces, which had controlling influences over drug dependent users. When the informants spoke of 'the spirit of drugs', they described this as a negative spirit which had powerful controlling influence that bound them to drugs. It did this by revealing to them how to fund their habits influencing them to use drugs, and through using drugs in dreams. This finding is supported by the African worldview that spiritual beings cause diseases. Adogame (1999), on Yoruba understanding of the cosmos, explains that malevolent divinities are primarily interested in the destruction of human beings. In this regard, it is believed that there are evil forces, which can control and affect humans negatively (Abimbola 1994). Westerlund (2006) also claims that in the Yoruba worldview, the spirits of ancestors, witches and sorcerers also play a role as agents of disease. On dream influences, the findings revealed that whenever a person who had been abstinent, dreamed of using drugs, he immediately resumed using drugs. McKenzie (1992)**,** on dreams and visions in 19th century Yoruba religion, tells us that dreams are predictive of future events. For example, they can be predictive of evil omens from spirits. Therefore, illnesses such as drug dependency are understood to have a spiritual dimension. This leads to the suggestion that spiritual problems are best resolved by spiritual interventions.

Furthermore, from the Christian Pentecostal spiritual perspective, the findings also suggest that drug dependency has a spiritual dimension. Drug dependency was

attributed by informants to lack of knowledge of God and demonic bondage. To support the lack of knowledge of God, the training of the agency emphasises the importance of the word of God and this constitutes the essential feature of the training. The word of God is seen as transformative, once a person acquires the word of God, the knowledge is acquired to do away with drug dependency. In addition, Wagner (1991) explains from Corinthians 4:4 that Satan blinds the minds of people who do not believe from knowing God. This lack of knowledge of God is explained in Romans 3:21-8:39 as the reason people do things that do not express the nature of God, things such as drug dependency. In this regard, drug dependency is the result of lack of knowing God and a lack being in a relationship with God.

Turning to demonic bondage, the findings suggest that the conditions of drug dependency were regarded as a form of demonic bondage. Brakeman (1999) explains that drug dependent persons are dominated in their mind, body and spirit by something outside their control, and are therefore unable to help themselves. She suggests that this condition requires the intervention of God. This loss of control over substance use is also regarded as a spiritual problem by Alcoholics Anonymous who believe a spiritual renewal through submission to a 'Higher Power' is the basis for restoration of the 'alcoholic' (Alcoholics Anonymous 2007). Furthermore, the doctrinal beliefs of the Redeemed Christian Church of God (2011) state that people can be under the control of unclean spirits. The practice of deliverance prayers as an intervention for breaking controlling influences such as drug dependence is carried out in response to this idea.

In summary, the findings reveal that drug dependence is a multi-factorial problem which includes spiritual dimensions. The implications for recovery are that spiritual matters must be attended to in the treatment and recovery process. From the perspective of the agency, it is believed that illnesses which have a spiritual dimension can only be cured through spiritual means; for those who believe, there is a real opportunity for recovery and renewal. Furness and Gilligan suggests that religion is one of the mechanisms for addressing issues (2010). This is an important message for policy makers and all those working with drug-dependent persons, believers and non-believers alike.

6.3 The recovery process

This section will explore three themes: motivation for recovery, disengagement from drugs, and maintenance.

6.3.1 Motivation for recovery

The discussion in this section is focussed on three themes: psychological, socio-environment and spiritual.

There were two main psychological findings. First informants were motivated into recovery when they reached a point at which they were tired of their drug

using lifestyle, that is, when they lost the desire for continued dependence on drugs and the associated lifestyle. Although this provided motivation for recovery, however, they were not able to stop using drugs on their own. This factor was particularly important for those who had been dependent on drugs for many years, and had experienced a lot of negative consequences from their drug using lifestyle. The negative consequences include harsh conditions of living, separation from loved ones and physical loss of loved ones through death. They claimed they decided to seek treatment because they were tired of using drugs and wanted to stop using. Their desire to stop using drugs was evidenced by their cry to God for assistance and their immediate response to the offer of treatment by the agency. The findings showed that when informants reached the point when they were tired of their drug using lifestyle, they were willing and ready for treatment. The findings agree with some ideas on motivation for behavioural change proposed by Miller and Rollnick (2002). They suggest that there are three important ingredients for motivation, that is, willingness, readiness and ability to change. Willingness was referred to as desire to change and readiness to be set for action. Going by these definitions, the findings support the first two ideas that willingness and readiness for change are important factors behind motivation. However, informants claimed that although they were tired of using drugs, they were still dependent on drugs because they could not come off drugs on their own and needed support to do so which most of them (with the exception of three persons) did not have. They had been separated from families who would have provided them with support and were living in joints or on the streets. Moreover, the government hospitals

providing care are not free. However, the finding that informants could not stop using drugs, even though they were tired of their drug using lifestyles, does not support the maturing out of addiction theory by Winnick (1962) and Prins (1995) which argues that a large proportion of drug addicts mature out of addiction when they reach their mid-thirties, by which time a person's personal and social identity has been built up.

The second findings suggest that that when drug-dependent users re-evaluate their drug-dependent lifestyles, they are able to make the decision to change their lifestyles. Similarly, findings from the study by Stimson and Oppenheimer (1982) show that many drug-dependent persons took the decision to stop using drugs when retrospectively assessing their lives, recognised a shift in the balance between the advantages and disadvantages of drugs. For example, the findings showed that the decision to change was mainly based on the realisation of the negative consequences of drug dependency. Furthermore, McIntosh and McKegany (2000) explain that when drug users were able to reflect on their drug using lifestyle they were creating a distance between themselves and the lifestyle. Such a distance, they claim, helps to construct a non-drug identity which is an important aspect of recovery. DiClemente (2003) believes that when a person is able to shift his view of addiction and evaluate the consequences it will lead to a decision to change. Therefore in the study, self re-evaluation was an important factor that motivated the informants to quit the drug-dependent lifestyle.

Findings also revealed that there were push and pull socio-environmental factors that motivated recovery from dependent drug use. The push factors were stigma, death of loved ones, and negative impact of drug dependent lifestyles. The pull factors were changed lifestyles of drug using friends, supportive non drug associates (including family relationships) and the offer of treatment. These findings are supported by evidence from literature. For example, Goffman (1963), defines stigma as the condition whereby an individual is disqualified from full social acceptance. He explains that this condition occurs when an individual possesses an attribute which makes him different from other categories of persons, and one that is less desirable. Therefore, that attribute causes the worth of an individual to be reduced in the minds of people. This description by Goffman, explains the reason drug dependent persons are stigmatised in the present study. One important response is that this condition motivated informants to get rid of drug dependency. Another important response was separation from drug using associates. Cohen (1955) suggests that when individual members of a subculture attempt to resolve a problem on their own, that is without the help of the members of the group, they find it difficult to belong to the group. These responses may provide ways of resolving drug dependency in drug sub-cultures.

Moreover, these findings also support the proposition by DiClemente (2003) that during the stage of moving from contemplation to taking actions for recovery, the discovery of the negative aspects of drug dependency and self-reevaluation, its consequence and of the potential benefits of change, affect the

decision to change. Therefore, this finding does not agree with the claims by Miller and Rollnick (2002) on motivational interviewing, that painful experiences such as humiliation, shame, and guilt are not the most important factors of change.

Furthermore, physical loss of a loved one was a significant factor because it created a vacuum in the person's life due to state of helplessness and despair caused by the loss of a valuable support. This is supported by evidence in literature. Marris (1986) explains how loss brings about a change. He suggests that the way we constitute the meaning of our lives is dependent on the way our purposes and expectations are organised about particular relationships and when such relationships are lost, the meaning centred upon it falls apart. This is shown by intense anxiety, restlessness and despair which result from bereavement. He suggests recovery from bereavement can be achieved, if it involves making good a lost relationship, in the context of life, that still makes sense. However, the question he poses which is significant to the study is how do you make sense of life when nothing seems to matter anymore? Marris suggests that anxiety and despair results from grief and despair drives a person to a restless search to recover meaning. In terms of the informants concerned, they had lost the people they had always relied to for help, people they could depend on. Fortunately, the experiences of loss made them re-evaluate their lives; they decided to stop using drugs and enrolled for treatment. However, taking the step to enrol for treatment was not immediate for many informants. Support from significant others such as a pastor, friend, or family member

enabled them to enrol for treatment. The implications of these findings are twofold: that is, loss can trigger the decision to quit drug dependency; and positive, supportive relationships are important in the realisation of change from drug-dependent lifestyles. The need for supportive relationships during the period of loss was emphasised by Golan (1981), particularly when such persons cannot help themselves as it is the case with the informants in the context of the study. Golan identified four sources of help; natural help system consisting of family, friends and neighbours; a formal and informal mutual help system; non-professional support systems which include voluntary organisations, community care givers, para-professionals and the professional help system. In addition, the findings also supports one of the findings in the study by Stimpson and Oppeheimer (1982), that triggers, such as loss influence some people to stop drug dependency. In the present study, this was helpful for those who did not have any plan to give up drugs. This kind of trigger of change has also been advanced by some researchers as turning points. Some of the studies which showed that turning points are instrumental to recovery from drug dependence are: Stimson and Oppenheimer (1982), on heroin addiction, treatment and control in Britain; McIntosh and McKegany (2000) of ex-dependent users' experiences of the process of recovery from drug dependence, and Haight et al. (2009) mothers' recovery experience of methamphetamine addiction: a case-based analysis of rural Midwestern women in the United States.

Other evidence from literature support other factors of motivation demonstrated in the present study. The influence of supportive relationships was supported by Miller and Rollnick (2002) who suggest that the probability of change will likely be influenced by interpersonal interactions. In addition, the studies by Stimson and Oppenheimer (1982) and DiClemente (2003) support the findings in this study that negative effects of drug dependency such as ill health and imprisonment are reasons some dependent drug users quit using drugs. Finally, the significance the support provided by the treatment centres was supported by the study by Stimson and Oppenheimer (1982) on treatment and control of heroin addiction in Britain. They suggest that the availability of free prescribing treatment centres encouraged people to engage in treatment. In addition, the knowledge that treatment offered by the agency was spiritually oriented encouraged service users to enrol for treatment. Findings also suggest that this is because most of the informants did not have success with other forms of treatment. In addition, the changed lives of former drug using associates who were no longer using drugs also encouraged service users to enrol for treatment at the agency. Miller and Rollnick (2002) suggest that specific interventions influence the decision to change. Therefore, the outreaches to the drug joints by the agency and other referral groups are a form of intervention that has proved effective in helping those in drug dependency to not only decide to change but to commit to change by engaging in treatment. Furthermore, the knowledge that it was spiritually oriented was an encouragement to some who had tried other forms of treatment and for some others, the evidence provided by the changed lifestyles of former drug-dependent persons suggest that the treatment offered by the centre was effective.

Spiritual factors of motivation

The main influence identified was the belief that God can help them get over drug dependency. It was indicated in most of the narratives that when the informants became tired of using drugs, they cried desperately to God for help. This shows that belief in God's ability to heal was important to them. The importance of spiritual factors is discussed in all sections on spiritual factors of drug dependency and recovery.

6.3.2 Disengagement from drugs

The findings revealed that two important psychological strategies which facilitated recovery are cognitive re-orientation and commitment to treatment. Regarding cognitive re-orientation, informants suggested that the teachings received and hope of a better life, helped them to re-orientate their thinking and consider recovery from drug dependency possible. The role of cognitive re-orientation in recovery was highlighted by Burman (1997), who suggests that developing an ability to change facilitates recovery from drug dependency. These findings are supported by Best and Laudet (2010) who recognise that hope and is important in recovery.

On commitment to treatment and recovery, literature suggests that it is an important ingredient for recovery from dependent drug use. DiClemente (2003) points out that breaking free from addiction requires commitment because it involves going through physical withdrawal and psychological loss which is often difficult, stressful and uncomfortable, particularly in the first few days. This is because the period of

withdrawal is often difficult, stressful and uncomfortable; he suggests they need endurance to get through the first few days. Informants in the study also attest to having a difficult period of withdrawal from drugs and some suggested that committing to the programme of treatment helped them in going through the programme and achieving recovery. The findings therefore support the idea that commitment is an important strategy for recovery. In addition, Bandura (1986) suggests that desire to change is not sufficient to bring about change if people do not have the means to exercise control over their behaviour. He said that self-regulation requires internal standards to assess or guide a person's action. This study shows that commitment is one of the internal standards that was important for recovery.

The study also identified that support from significant others, possessing a new identity, confinement and comfortable residential environment, were all important socio-environmental strategies for recovery. Support from significant others was particularly helpful during the period of withdrawal from drugs. Informants suggested that the care-staff, who had passed through treatment, provided counselling, support, inspiration and supportive care, which helped them, particularly when withdrawing from drugs in the first week. This finding furthers previous research evidence that support from significant others such as health workers, family, and peers are an important factor in recovery from drug dependency. Robertson and Wells (1998) suggests that withdrawing from drugs is known to be unpleasant and what is needed to achieve abstinence is encouragement to go through the process, supportive care and empathy. In addition, Khantzian and Mack (1994) shows that peer support offered by A.A. members helped other members to achieve self-

regulation from alcohol dependency and overcome vulnerabilities such as poor self-esteem and depression which literature suggests contribute to dependent drug use. The importance of peer support is also affirmed by Laudet et al. (2006) who suggest that social support and 12 step affiliation buffers stress and enhances the quality of life among recovering individuals. Other studies have advanced that this is of importance in the action and maintenance stages. For example, reviews by Klingemann (1994) suggest that social support is important, particularly in the action and maintenance stage of recovery. DiClemente (2003), also emphasises that supportive relationships are important for recovery in the action stage. More recent studies also support this proposition. For example, Cloud and Granfield (2008) suggest that persons in possession of social capital such as group support and supportive relationships are in a better position to initiate and sustain recovery. Furthermore, the study by Laudet (2008) reveals that persons in recovery cited the support of family, friends and peers as one of the important factors in abstaining from drugs. Best and Laudet (2010) also emphasise the potential that individuals who are successful in recovering have to transmit recovery within the community. Recent policies such as U.K. Home Government (2010) Drug Strategy have built on these ideas. For example, one of the central planks of the government's strategy in achieving recovery is to build on 'recovery capital'. This is to be done by building social capital (e.g. family, partners, children, peers and friends), physical, human and cultural capital by supporting services working with individuals and drawing on these recovery resources available to the individual.

Turning to the discussion of identity, the findings suggest that when individuals saw themselves from a different perspective, they became able to separate themselves from their past lifestyles of drug dependency and embrace a new lifestyle. One informant explained that when he conceived a new sense of self, of who he was as a Christian, that is, a new man and one chosen by God, he embraced God and according to him, 'began to live a new life again'. The finding supports the idea by McIntosh and McKegany (2000) and (Grant 2007) that the ability of the individual to construct a non-addict identity is an important aspect in the process of recovery from drug dependence.

The present study also found that confinement promoted recovery from dependent drug use. The term confinement refers to restricting service users to the residential facility during treatment. It also implies a situational change, away from drug using environments. This factor in recovery was also advanced by Robins (1993) and Blomqvist (2002). Residential care for most of the study informants provided an alternative environment from drug using environments which promoted drug use through the ready availability of drugs and communal use which encouraged drug dependency. This distance helped to separate the informants from the negative influences of drug using environments, therefore helping them to focus on recovery. This finding is supported by DiClemente (2003), who argues that change from dependent behaviour can be achieved when the individual is most distanced from the addictive behaviour. Therefore, when drug-dependent persons are distanced from influences which promote drug use, such as drug using environments, peers and sources, recovery can be enabled. These finding demonstrate the importance of

residential care in recovery and support other findings. For example, the outcome study of the therapeutic communities by Daytop International (2006) reveal that positive treatment results from a minimum of six months of residential care.

Finally, the findings suggest that access to comfortable residential facility and resources facilitated recovery from drug dependency. The significance of this factor is that it provided encouragement for the service users to stay in treatment. The finding also provides additional evidence of claims by Rethink (2009) on getting back into the world, that the provision of basic and material needs facilitate the process of helping people to get back to the world.

Moreover, findings suggest that there were three important spiritual strategies of recovery; salvation, prayers and teaching of the word of God. This was reflected both in the narratives of the service users, interviews with staff of the agency and in the agency's manual. Salvation was described as a transformative experience. The service users described salvation as accepting God and surrender of the self to God. This experience was said to have brought about a change of heart and liberation from drug dependency and associated lifestyles. I also observed during fieldwork that the first, treatment intervention was the offer of salvation. This experience of salvation, which is also referred to as being born-again, was explained by Adeboye (2001) in his work on the new life. Basing his argument on John 14:20, he suggests that for anyone who is born again, the holy God in-dwells the person. Therefore, he explains that the attributes of God manifest in the person and anything contrary to God's

attributes do not. For example he explains that because God is love, it is not possible for hatred or un-forgiveness to be in that person if God is in dwelling in the person. Therefore he claims that anyone who is in Christ is redeemed. In addition, he suggests that a person who is born-again has the wisdom of God, which he also refers to as the fear of God which keeps from sin (2001:4-8). Furthermore, he suggests that the person must be willing to put old lifestyles behind them and make a fresh start; they must walk in this new life and become a brand new creature. This perspective was also corroborated by Oyedepo (2005) who suggests that when a person receives Jesus Christ into his life, he receives forgiveness and is redeemed from the power of sin and separated unto God and the person walks in the newness of life. This understanding is similar to that experienced by the informants in the study. The evidence suggests that salvation is a transformative experience and an effective intervention for recovery from drug dependence.

Some studies on African Charismatics have also revealed that salvation is a transformative experience and attempted to explain how this change is brought about. The study Ukah (2008) on the R.C.C.G. reveal that being born-again is a transformative experience that brings about a re-orientation and beliefs, values, and practices that are patterned on Godly principles. Besides, he suggests that being born-again makes provision for persons who make such claims as to be a part of a body of believers, and provides a new form of social identity for Charismatics. He suggests that salvation provides hope for eternal life. Furthermore, the study by Asamoah-Gyadu (2005), on independent indigenous Pentecostal missions in Ghana, likewise indicates that receiving salvation results in transformation, empowerment,

healings, deliverances, prosperity and success. These positive experiences are similar to the findings in the study, which showed that receiving God can be an all-round transformative and beneficial experience, hence an important factor in recovery from drug dependence

Similarly, studies on spirituality and recovery, particularly on the A.A. and other 12 step programmes have shown that spiritual renewal such as described above is effective in recovery from drug dependence. Peteet (1993) suggests that sustained recovery was attributed to being able to 'let go and let God' in the A.A. phrase. Besides, he suggests that aligning the self to God as source of strength, acceptance and inspiration is important to the recovery process. A.A. (2007) in addition to this states that the higher power brings about the change, which a person cannot do for himself. Other researchers such as Green et al. (1998) claim in their study on stories of spiritual awakening that when persons in recovery embraced a higher power other than self, it results in life altering transformations. They also state that it leads to a spiritual journey that resulted in abstinence from dependent drug use. Wright (2003), also suggest that surrender to a Higher Power, referred to as God or Jesus Christ, is the beginning of a spiritual journey toward spiritual recovery. She explains that sincere repentance, purging the self, and confession produce genuine surrender. Since the concept of a higher power means different things to different religious groups, the concept of higher power was understood by informants in the study, to mean the concept of God as understood by the Christian faith. They ascribed their belief in a Higher Power by referring to God or Jesus Christ. Similarly, when informants in the study received salvation, the experience was transformative.

The findings from interviews and written materials also demonstrate that prayer is a key part of the recovery process, and prayers (communal and individual) are a part of the day to day practices in the agency. Two important prayer strategies facilitated recovery; deliverance and personal prayers. Interviews with service users revealed that deliverance prayers were beneficial. They claimed that it brought about a severance from evil spirits such as the hearing of strange voices, which is believed to influence dependent drug use. This shows that spiritual issues were resolved through spiritual interventions. This finding agrees with Oyedepo (2005) who states that spiritual influences make people do what they don't want to do and getting rid of them requires a spiritual approach. Other benefits of deliverance prayers include conversion, baptism of the Holy Spirit and spiritual and physical empowerment. There were also claims of healings being experienced, such as relief from withdrawal symptoms like body pains, physical weakness and poor appetite, and exiting of cravings. This in turn helped service users to be free from drug dependency. Since the healings resulted from prayers and not medical assistance, it supports the idea that physical disease can be cured by the supernatural intervention of God (Adeboye 1994; Alexander 2006; The Redeemed Christian Church of God 2011).

Regarding personal prayers, the findings suggest that these were an important resource which helped many informants to achieve sobriety in this study, especially those who were still experiencing cravings and negative affective states. In addition, it helped in breaking off negative dream influences (which was identified by informants in 4.3.3 as a major factor in drug dependency and relapse). By engaging this tool, service users were able to complete treatment and attain sobriety. Similarly,

several studies also suggest that prayer plays an important role in recovery from drug dependency. According to Green et al. (1998), informants in their study acknowledged that a higher power outside of themselves initiated changes from drug dependency and provided the resources necessary for abstinence. For example, he said that one informant in the study claimed that whenever he craved drugs he would pray that: 'Lord grant me serenity' (1998:327). They also suggest that the Higher Power was a daily presence in the individual's life and far from being an abstraction. He explained that through prayer and meditation with a higher power, informants were provided with the opportunity for reflection in times of trouble. Furthermore, other studies provide evidence of the efficacy of prayers as an instrument for healing and deliverance. Lloyd-Jones (1988), in his book on healing and the scriptures, reveals that divine healing provides cures from demonic oppression and possession. Lloyd explains that spiritual problems are best handled through spiritual means. He explains that faith healing is a divine act which is obtainable through persons whom God has chosen, through the prayer of faith, based on the scriptural principle of prayer in James 5:15 and Mark 11:22-24. Hardesty, (2003), in her book on faith cure, provides evidence of spiritual healing from various illnesses through prayers. Further, Alexander (2006), on Pentecostal healing, provides examples to show that prayer is one of the instruments for obtaining spiritual healing. Similarly the findings on prayer revealed that healing is a significant aspect of recovery in the sense that it facilities relief and or removal of physical and emotional pains, which could hinder recovery. In addition to these studies, Adogame (2005) in his study of Aladura churches in Nigeria, reveals the importance of prayers in the study context. He points out that prayers are seen as a panacea to all existential problems. These include

physical healing from illness and sickness, spiritual, material, psychological and moral well-being. Further, he shows that the study group in his research conceived prayers as an instrument of spiritual power. Therefore, he explains that prayers were engaged actively to find solutions to their needs and provide protection against evil forces. The findings of the present research also reveal that the service users believed in the efficacy of prayers.

The findings also suggest that tuition played an important role in recovery. Interviews with service users revealed that through the training programmes and bible studies, they experienced behavioural changes, loss of desire for drugs and removal of negative affective feelings. This finding is significant because the cravings that influence drug dependency also prevent people from completing treatment if not addressed. Furthermore, since this and other problems were alleviated through the training programme, it provides evidence that this intervention played an important role in recovery. Literature suggests that personal capita are an important personal resource for recovery (Best and Laudet 2010).

The experiences of informants also showed that Bible reading and meditation provided nurture for the soul, defence against negative thoughts and facilitated the adoption of a new lifestyle. Literature on spirituality and recovery suggests that Bible study and meditation play an important role in recovery. For example, Wright (2003) on spirituality among African women recovering from substance abuse, points out that Bible study, meditating or walking in the park, may provide nurture for the soul

and engage one in purpose and meaning. On negative thoughts, literature suggests that negative affects influence drug dependency. For example, the findings in Khantzian's study, suggest that this condition makes alcohol dependent persons, prefer consuming substances than experience the feeling (Khantzian and Mack 1994). The implication of this for recovery is that when negative effects are addressed, recovery can be enhanced, as the findings in this research suggests. Regarding adoption of a new lifestyle, findings suggest that Bible study and meditation facilitated the adoption of a new lifestyle through what is learnt and through focussing on new values. This finding also revealed that internal standards which facilitate recovery can be developed through the reading of the Bible and meditating on it.

6.3.3 Maintenance of recovery

Discussions in this section focus on psychological, socio-environmental and spiritual strategies for sustaining recovery.

The three main psychological strategies were positive self-talk, the avoidance of triggers of drug dependency and adoption of alternative non-drug lifestyles. It was identified that positive self-talk helped as a defence against cravings and in achieving abstinence. It also helped to remind the informants of the benefits of recovery. The importance of self-talk in recovery was recognised in the study by Burman (1997). This study suggests that through self-talk, some study informants guided their

thoughts to reinforce their decision to abstain from drugs. Furthermore, it helped as a defence against cravings and environmental cues.

Avoidance of triggers of drug dependency, including abstinence, also helped some service users to sustain their recovery. It is important to note that the informants being discussed were those in the vocational training programme and those who were successful with treatment. These persons were re-introduced into society after treatment. Being in a larger society, they were exposed to drug cues like places where drugs were sold, the smell of drugs and former drug using associates as well as negative feelings such as anger and personal concerns. Some informants claimed that these were real challenges to them. These claims agree with the proposition by Drummond (1995), that these external and internal cues are the sources of drug cravings. Glautier (1995) explains that when drug cues are experienced, they lead to an operant behaviour, such as seeking out drugs and experiencing drugs. However, although this theory proffers reasons for drug dependency, the findings in this section showed that cravings do not always lead to seeking out and using drugs. One of the counter conditioning measures adopted was the avoidance of these triggers of drug dependency and remaining abstinent from the drug. DiClemente (2003) suggests that for behaviour change to occur, one of the demands is the breaking of the link between the cues and behaviours. Moreover, some research findings such as Betty Ford Institute Consensus Panel (2007), White (2007) and Laudet (2007) suggest that one key element to recovery is abstinence from drugs. Furthermore, Laudet (2008) recommends that this is a prerequisite to other benefits of recovery. Although there is no consensus among researchers and practitioners as to whether recovery means total

abstinence from all drugs, several researchers show that most recovering persons view recovery as total abstinence. The study by Laudet (2007) showed that 87% of study informants stated that recovery to them meant total abstinence. A review of other studies by Laudet (2008) reveals that abstinence provided the most success with remissions and the most failed remission attempts are based on moderation. Similarly, research informants in the study claimed that abstaining from drugs helped them to achieve recovery. As suggested by Chris, one of the informants who had just completed vocational training, partial abstinence means that 'the person is on holiday' from drugs and will eventually resume using drugs.

In addition adoption of alternative non-drug lifestyles, such as positive attitudes, self-development and gainful employment further helped to sustain recovery. These helped to establish a new pattern of behaviour. For example, to commit to recovery, service users took self-liberating actions such as self-discipline, determination, frequent baths and engaging in constructive talk and prayers. To manage drug cravings, findings showed that the informants identified the triggers of drug use which were peculiar to them as individuals and managed these. Also, through self and career development, they did not return to their old lifestyles and were able to avoid a relapse when they returned to normal social environment after treatment.

The main socio-environmental factor was supportive networks which helped them to sustain recovery. This finding supports many research findings and propositions that recovery is achieved with the support of significant others. For example, reviews by

Klingemann (1994) shows that social support is important, particularly in the action and maintenance stage of recovery. DiClemente (2003), also emphasises that supportive relationships are very important to recovery in the action stage. Recent studies also support these propositions. For example, Cloud and Granfield (2008) suggest that persons in possession of social capital such as group support and relationships are in a better position to initiate and sustain recovery. Furthermore, the study by Laudet (2008) revealed that persons in recovery cited the support of family, friends and peers as one of the important factors in abstaining from drugs. Best and Laudet (2010) emphasise the potential that individuals who are successful with recovery have, in transmitting recovery within the community. Recent policies such as U.K. Home Government (2010) Drug Strategy have built on these ideas. For example, one of the aims of the strategy aimed at achieving recovery is to build on the recovery capital available to a person, such as the social capital, (e.g family, spouses, children, peers and friends), physical, human and cultural capital, by supporting services that work with individuals and encouraging them to draw on these recovery resources available to the individual.

The spiritual strategies identified for maintaining recovery were Christian lifestyle, prayers and empowerment by the Holy Spirit. First, the informants suggested that Christian practices such as daily devotions, daily reading of the Bible, praying and attendance of church services, obedience to the word of God, and submission to God, helped them to grow spiritually. Their experiences showed that some of these Christian practices such as prayer and the word of God were tools that were drawn upon whenever there was a temptation to use

drugs. For example, many of the informants suggested that they tapped on the knowledge of the word of God to combat negative experiences. The scriptures also provided defence against cravings and all negative experiences. Some of the benefits of the Christian lifestyle were explained. This in turn helped them resist returning to drug dependency. Adeboye (2001) and Oyedepo (2005) suggest that it is essential that a person who is born again is willing to make a fresh start by beginning a new life in God. This new walk with God is regarded as sanctification (Adeboye 2002). It includes obedience to the word of God, love for God, (Adeboye 2002), study of the word of God, casting off unrighteousness, and gaining righteousness. In addition Oyedepo (2005) also suggests that the word of God cleanses, when a person pays attention to it (Oyedepo 2005).

Second, the informants also utilised various prayers to counteract cravings and other temptations such as scripture praying, rebuking the devil or the negative conditions and positive confessions. This was especially helpful in managing cravings. This corroborates earlier findings in section 5.2.3 that prayers are effective in counteracting the effects of cravings. The efficacy of prayers in annulling drug cravings has been discussed in section 6.2. The findings agree with Oyedepo (2005) and Hagin (1979) that using the name of Jesus against the devil and demanding that the sickness and disease leave is effective. Third, it was also identified that divine empowerment by the Holy Spirit helped some informants to maintain their drug free status. This was experienced in three ways: the ability to separate self from peer groups and associates, the ability to

enjoy a Christian lifestyle (such as reading the Bible) and empowerment to live a non-drug lifestyle. This finding supports the view of the Holy Spirit's influence in the transformations experienced by believers (Asamoah-Gyadu 2005). The findings above demonstrated that ability to enjoy a Christian lifestyle and live a non-drug lifestyle was ascribed to the Holy Spirit.

In summary, the findings in this section reveal that recovery was sustained through adopting a Christian lifestyle and the special work of the Holy Spirit. At the centre they worked towards achieving this. The evidence supports the view by (White and Kurtz 2006) that recovery is a personal condition which can be achieved through different routes including spiritual.

6.4 Implications for Policy, Practice and research

The implications of the findings of the study for policy, practice and research are discussed.

6.4 1 Implications for policy and practice

Several implications can be drawn from the study for policy and practice. The findings that drug-dependent persons found it difficult to stop using drugs on their own and spent long years (between 10 and 35 years) in drug dependency confirms what is already known from previous research (e.g. White and Kurtz 2006) that drug dependency is a difficult problem that drug-dependent persons need support to overcome. This calls for the attention of policy makers to do more for drug-dependent users, and in the context of this study, this also calls for more treatment facilities. The establishment of programmes that provide counselling services may help reduce the incidence of drug dependency. In addition, the major problems which were found to exacerbate drug dependency in the study such as cravings, withdrawal symptoms and loss of self-regulation, need to be addressed in treatment. The findings of the study showed that cravings can be mitigated or controlled through interventions such as positive self-talk. Furthermore, the findings also showed that drug dependency has a spiritual dimension to it and this should not be ignored. All of these areas will now be discussed in more detail.

Motivation was found to be of central importance for recovery from dependent drug use. The relevant factors here were self re-evaluation, social support and the offer of free treatment from a Christian agency. These are discussed in turn:

- Self re-evaluation enabled informants in this study to reconsider quitting drugs for a drug-free lifestyle. This finding supports previous research by McIntosh and McKeganey (2000) and DiClemente (2003). The implication for practice is that service users should be encouraged to explore their former selves (before they took drugs) and their current lifestyles, in order to allow them to shift their focus towards recovery.

- It was found that the positive role models provided by recovered persons inspired informants to engage in treatment, thus reflecting the importance of social support in recovery (also discussed by Best and Laudet (2010)). The implication for practice is that reformed drug users should be brought into practice settings to encourage those coming into treatment, as well as support those undergoing treatment.

- The study revealed, interestingly, that the offer of free help from a Christian agency was probably the greatest single motivational factor for the informants. The offer of treatment provided the trigger that enabled informants to take positive steps and enrol for treatment; the fact that help was offered free and from a Christian organisation was important to informants because of their social situation (most informants were poor and could not have paid for treatment) and their values (all held a common belief that only God could help them recover from drug dependency). This has very significant implications for policy and practice; it suggests that to be truly

useful, services must be socially and culturally relevant, as also demonstrated by other researchers (White and Kurtz 2006; Best 2010).

Another important aspect for policy and practice arising out of this study focuses on the residential nature of service-provision. This study has revealed (over and above the issues already discussed above), that the fact that the service offered was a residential one was hugely significant to informants. Confining dependent drug users in a residential facility helped them to sever ties with drugs, with drug-using environments and with their old, drug-using friends; separation from their former lives then allowed them to try out new ways of being in a safe, controlled environment. This builds on a Therapeutic Community model of treatment (Perfas 2006) and lends support to residential rehabilitation programmes in the future. It is not enough, however, to simply provide residential care; it is the quality and nature of that care which was found to be crucial for recovery. This study has shown that the facilities should provide for the basic needs of service users (Rethink 2009) but they must also include a range of treatment options (including individual counselling and group sessions) as well as training. In Wellspring's setting, this was very focused on preparing for employment and for a new lifestyle without drugs. It was also, significantly, built around spiritual training, which again gave informants new ideas and new skills to take them forward into their new lives.

The spiritual/religious aspect of this requires further consideration. The findings from interviews with service users demonstrate that the most significant factor which

helped them to disengage from drugs was the spiritual intervention received, such as salvation, prayers and the training programme (which included bible studies). Salvation was central to recovery in the sense that it was believed to have brought about a change of heart and transformed lifestyles enabling informants to move away from former drug-using lifestyles. Prayers either mitigated cravings or helped to control them and were also effective in combating bad dreams which influenced people to use drugs. The training programme provided service users with knowledge, most especially the knowledge of God, and the tool of the word of God which was drawn on to combat drug dependency. The intervention resulted in behavioural changes, positive attitudes and character (internal standards) which were drawn on in order to withdraw from drugs, lose the desire for drugs and remove the negative affective feelings which promote drug dependency. This again reiterates the relevance of faith-based treatment in recovery. It shows that the model enables self-efficacy, which is an important aspect of recovery, thereby supporting the view that belief and personal capital are important for recovery.

This study therefore reminds us that faith and belief remain vital in recovery-journeys for many people in Nigeria. Many conventional Western approaches to drug treatment and recovery have relied on secular methods and understandings, but might not faith and belief also have a role to play in recovery in the developed world? Writing about social work in the UK, Gilligan and Furness have argued that social workers must be able to respond appropriately to the needs of all service users, including those for whom religious and spiritual beliefs are crucial. They argue that practice which is ‘culturally competent’ depends, amongst other things, ‘on an

understanding and appreciation of the impact of faith and belief' (2006: 617). This suggests the need for the inclusion of a spiritual assessment in clinical settings so that practitioners are better able to respond to the spiritual needs of service users; such an assessment might be included in the initial assessment plan. It may also be helpful for secular agencies to build relationships with alternative faith-based settings so that they can refer people on appropriately as the need arises. This idea is similar to that proposed by the 2010 U.K. drugs strategy which suggests linking service users to communities of recovery such as the A.A. as part of the treatment plan for recovery (HM Government 2010).

Another important implication for policy and practice is centred on the issue of abstinence. The findings reveal that abstinence from all drugs was highly significant in sustaining recovery. Using other or lesser substances was seen by informants to be a gateway to resumption of drug dependency; one informant said a person who smoked was 'only on holiday' from using drugs. The implication is that service users need to be moved onto living drug-free lives. The finding supports other key research (Laudet 2007) and is very important for policy makers and practitioners who are interested in recovery from use. In addition, the findings also sustain the view that recovery is a voluntarily-maintained lifestyle, as proffered by the Betty Ford Institute (2007). This suggests that recovery cannot be coerced, but that dependent users should be motivated and supported in order to fully embrace recovery from dependent drug use. This means giving them a range of options and supporting them in their recovery journeys with the options that work best for them.

But recovery is not a one-off event. This study has shown that there needs to be a shift from harm minimisation to a process of sustained recovery management (White and Kurtz 2006; National Treatment Agency for Substance Misuse 2011). This should include continuing care from initiation stage to sustained and stable recovery. Post-treatment care might usefully include continuing care from counsellors, post-treatment check-ups and alumni meetings. An aspect of the care should also include drawing on recovery capital, during and after treatment (Best and Laudet 2010), which includes personal capital (coping skills and a non-drug identity), social, financial and spiritual capital (see section 2.4.5). Vocational training plays an important part here, alongside relapse prevention training and treatment, medical and non-medical. Connecting with recovery communities is also found to be helpful, in order to strengthen recovery initiation, link persons and families to these agencies for support and to render communal guidance for transition from initiation to sustained/stable recovery (White and Kurtz 2006; HM Government 2010). White and Kurtz advised that the strength and durability of the networks will need to be monitored (2006).

Finally, the study suggests that recovery is visible. If visible, then recovery is achievable by exploring the routes that have enabled dependent drug users to recover from drug dependency. This has fundamental implications for policy and practice.

6.4.1 Recommendations for further research

This study has shown the important role of faith and spirituality in recovery from drug use in Nigeria. This leads to a great many other questions, such as how relevant are these findings for drug treatment agencies in the UK and to what degree should social work and health care agencies take account of the faith and belief of those with whom they are working? Should spiritual training become part of social work education?

The study also draws to mind some focused questions. It has been noted that role models and peers are important in recovery. Could more work be done in this area? Similarly, the majority of informants in this study were men. Could more be done to access the views and experiences of women, who clearly have a very different trajectory through drug use? Furthermore, it was revealed that residential programmes facilitated recovery. Could more also be done to assess the role of residential programmes in recovery? Again, the study shows that abstinence from all psychoactive substances (including tobacco) is key to recovery. Can abstinence be sustained by those who have abstained from major drugs and are still smoking or using other drugs? Another important finding is that recovery is a person-centred journey and this includes the spiritual. Can the importance of this to recovery be assessed in both secular and faith based agencies?

Other aspects of the findings can also be explored in more detail. I employed a case study approach in order to investigate in detail how dependent drug users recover

from drug dependency in a Pentecostal faith-based agency. What other case studies might be used to explore this topic further, in other parts of the world? Comparative studies and more studies on faith-based initiatives should be considered to provide more understanding on recovery from all service providers. Furthermore, outcome and process research on faith based initiatives could be commissioned to determine the effectiveness of these interventions in the context of study.

6.5 Conclusion

This thesis has explored the concepts of drug dependency and recovery from drug dependency. Bearing in mind that recovery from dependent drug use is a new paradigm that needs to be understood better, the focus of this study has been to identify a broad range of factors that promote drug dependency and recovery. My analysis was based on experiences of service users of drug dependency and centred especially around three key themes on recovery identified in the research literature: motivation, disengagement and maintenance of recovery.

This study used a case-study approach, built on the experiences of service users in one agency, the Wellspring Rehabilitation Centre, Lagos, Nigeria, in order to enable an in-depth exploration of the concept of recovery. I adopted a qualitative study which enabled in-depth investigation of the concepts being studied.

This study makes a number of contributions to the field of drug dependency and recovery; perhaps the most significant is that there was found to be a spiritual dimension to drug dependency and recovery that should not be ignored by policy makers and practitioners. The informants in this study demonstrated that Pentecostal Christian interventions such as salvation, prayer and training in Biblical principles contributed immensely to their recovery from dependent drug use. This suggests that spiritual and religious approaches to treatment and recovery may be helpful in working with other drug dependent service users in other contexts, and should, at the very least, be considered alongside other areas such as personal, social and cultural approaches.

The study recommends that future research could explore, among other topics identified (in section 6.4.2), more faith-based initiatives and comparative studies to provide more understanding of recovery from a wider representation of service users.

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Appendices

Appendix 1 -Types of drugs and common names

A comprehensive compilation of drug types and their street names compiled by Teeson et. al., (2002) presented below:

‘1. **Cannabinoids -** Acapulco gold, Afghani, a stick, bhang, boo, bomb, brick, Buddha, sticks, dope, Columbian, ganja, gold, grass, hash, hashish, hay, hemp, j, Jane, jive, joint, key, marijuana, Mexican, MJ, oil, pot, reefer, rope, stick, Thai sticks, THC, and weed.

2. **Cocaine -** Blow, C, Charlie, coke, crack, dust, dynamite, flake, gold dust, heaven dust, lady, nose, nose candy, rock, snow, speedball, toot, and white.

3. Amphetamines-Bennies, blue angels, Chris, crystal, ecstasy, ice, meth, pinks, speed, speedball, uppers, ups, and whites.

4. Hallucinogens - Acid, blue dots, blue meanies, gold tops, ketamine, LSD, magic mushrooms, mesc, microdot, psilocybin, special K, tabs, trips, white lightening.

5. Inhalants and Solvents - Glue, petrol, nitrous oxide, laughing gas, amyl nitrate, rush, and ethyl.

6. Sedatives and Tranquilizers - Amies, blue birds, blue devils, blue heaven, blues, bullets, candy, dolls, barbiturates, barbs, downers, down, Librium, mogadon, normison, quads, rohypnol, serepax, sleepers, sleeping pills, transqs, yellows, valium, and xanac.

7. Opioids - Brown, black (opium), cat, codeine, doloxene, H, home bake, heroin, horse, junk, methadone, morphine, Percodan, poppy, scat, skag, smack, and tar.

8. Phencyclidine (PCP) - Angel, cheap cocaine, green, K, mist, purple, super coke, super grass, whack.'

Appendix 2 - Questionnaire guides for the study

Questionnaire Guide I – (Sustained sobriety group)

1. Can you tell me about yourself about the circumstances that led you to engage for treatment?
2. What goals did you hope to achieve?
3. How did you stop using drugs?
4. What challenges did you experience?
5. How did you overcome these challenges?
6. Are there other problems which affected your recovery?
7. How were these overcome?
8. What to you is the most important intervention offered by the agency?
9. How did this help you to recover and maintain recovery?
10. What other factors have aided your recovery and explain how it happened?
11. What are the evidences to show that you have recovered from dependent drug use?
12. Having recovered, how do you define recovery?
13. Please explain how you would advise someone who needs help from drug addiction to recover.
14. What suggestions can you proffer to improve the services of the agency?

Questionnaire Guide 2 – (In-treatment group)

1. Can you tell me about yourself about the circumstances that led you to engage for treatment at the agency?

2. How did you stop using drugs?

3. What were your experiences when you had to withdraw from the drugs and which was the most significant?

4. How did you cope and what would you consider to be the most important coping strategy?

5. What were the interventions provided by the agency that is aiding your recovery?

6. Which do you consider the most important and why?

7. How did that factor assist you in stopping and maintaining abstinence?

8. What other factors are aiding your recovery and explain how it happened?

9. Please summarize the challenges you are facing and what your coping strategies are.

10. What are the evidences to show that you are recovering from dependent drug use?

11. What would be your recommendations for how services should be improved?

Questionnaire Guide 3a (Unsuccessful group- Drop-offs)

1. Can you please tell me about yourself?
2. What factors motivated you to engage in treatment when you did?
3. What difficulties did you experience when withdrawing from drugs?
4. What did you do to resolve these difficulties?
5. Are there other problems you were experiencing which made recovery difficult?
6. What did you do about these problems?
7. What help did you receive?
8. Do you desire to be back for treatment at agency for treatment?
9. What will be the goals you hope to achieve in treatment?
10. What to you is the most important intervention offered by the agency and explain why?
11. Please give suggestions that will aid the agency to improve its services.

Questionnaire Guide 3b (Unsuccessful group- relapsed)

1. Can you please tell me about yourself?
2. Can you tell me about yourself about the circumstances that led you to engage for treatment at the agency?
3. How did you stop using drugs?
4. What problems did you experience that made your recovery difficult?
5. What did you do about these problems?
6. What help did you receive?
7. How long did you stop using drugs after treatment?
8. Please explain what factors that caused you to start using drugs again.
9. Do you desire to be back for treatment at agency for treatment?
10. What will be the goals you hope to achieve in treatment?
11. Please give suggestions that will aid the agency to improve its services.

Questionnaire guide 4 (Families of individuals who have recovered from dependent drug use)

1. Can you please tell me about yourself?
2. What is your relationship with the service user?
3. What were the problems associated with the dependent use?
4. How did the drug taking behaviour of the service user affect you and other members of the family?
5. What role did you play role in his/her recovery
6. How did your role assist the service user in achieving recovery?
7. How would you define recovery from drug dependence?
8. What is the evidence of recovery from your experience with the service user?
9. How are you assisting the service user to maintain the recovery status?

Questionnaire Guide 5 (Staff of Agency)

1. Can you please tell me about yourself?
2. What is your role in the agency?
3. What problems does dependent drug use present?
4. What programmes have the agency designed to resolve these problems?
5. How does the programme of recovery work?
6. What are the challenges being experience?
7. How do you cope with the challenges?
8. How will you define recovery from drug dependence?
9. What are the evidences of recovery?
10. How is recovery being maintained?
11. What are the main factors of relapse?
12. How relapsed being prevented?

Appendix 3- Wellspring Rehabilitation Centre's Intervention

This section provides additional information on the activities and interventions, drawn on field observation, informal interactions and formal interactions with staff of agency.

Daily Routines at Wellspring Rehabilitation Centre and observed processes

The start-up time for morning devotion commenced at 5am.After this service users take care of themselves. The training programme for each day starts at 10 am to 12noon (This sometimes may extend beyond this to about 1pm) After this period they have their lunch and rest. They reconvene at about 8pm for night devotions which usually last for an hour. Incorporated into the programme are the wellness rules and regulations which guides the behaviours and interactions among the residents. A formal undertaking is made by each service user to comply with the rules of the centre. Any beneficiary who repeatedly contravenes or violates his/her pledge to honour the regulations faces expulsion from the programme.

During my field work, I observed that daily routines at the camp were followed in a timely manner by the in-treatment group. The service users were well behaved and interacted well with one other. Discussions with a care-staff on the new intakes who were admitted two weeks before the termination of my field work suggests their behaviours were appropriate, as also observed, although some were quiet and weak due to the withdrawal symptoms. In addition, the care-staff were always on ground

and cared well for the service users. They supervised the daily activities and conducted the daily devotions. Sometimes they took part in the cooking, and attended to their needs.

Furthermore, I observed the deliverance prayer sessions. On the first day, I observed that although many service users were weak, as the prayers commenced, they started to regain their strength and participated actively in the prayers. The prayers addressed several issues especially breaking of covenants associated with the past lifestyles of drug dependency, severing ties with malevolent forces and making positive declarations about their lives. By the third day, most of the service users were looking physically stronger. I also noticed that there was significant improvement in their appearance from the unkempt looks they had when admitted. These observed processes and interactions with the service users equipped me with first hand knowledge of how people withdraw from drugs, the difficulties encountered, how these are resolved, and the support received. All of these greatly improved my understanding of the recovery process.

The role of the treatment intervention by Wellspring Rehabilitation Centre in recovery

This section focuses on the role of treatment in recovery, especially the training, counselling and other intervention. Challenges are also presented. Interventions such as salvation and prayers have already been discussed in sections 1.10 and 5.3.3.

Training intervention

The training programme of the agency and its objectives are discussed in chapter 1. To re-state, training for recovery is conducted in two phases: the five months in-treatment programme of recovery to two years vocational programme W.R.C. (2003) . Some of the objectives of the first programme are to assist service users to come off drugs, develop self-efficacy and social functioning, adopt positive lifestyles, and stay off drugs permanently. The objective of the second phase of the training is to facilitate social re-integration, through vocational training. The curriculum structure of the first phase of training is divided into three: Bible doctrines, motivational courses and social studies. An examination of the curriculum showed that the Bible based courses can be regrouped into three:theology; Bible doctrines (salvation, repentance, discipleship, the Word of God); and Christian living (such as obedience, prayer, praise and worship, holiness, integrity, stewardship, fruit of the spirit, submission to authority). The motivational courses set out to prepare an individual for success in life, through training in financial prosperity, goal setting, positive attitudes, purposes and pursuits, greatness, giftedness, confidence building, principles of success, creative thinking, and principles of communication, biographical studies and moral instruction. The social courses consist of a wide range of courses, including setting up small scale businesses, business ethics, social ethics, English language, and courtship, marriage and family life. There are also individual counselling sessions, group therapy and career counselling. Another aspect of the training includes relapse prevention.

An interview with the training coordinator gave additional insights into the training intervention, particularly the vocational programme. He suggested that the treatment programme is faith-based, and aimed at abstinence. He also claimed that this is what makes the treatment effective, appreciated by service users. He also state that during the period of withdrawal, prayers are supported by motivational talks and counselling, aimed at helping clients to receive motivation to continue with treatment.

He referred to the second phase of treatment, the training intervention, as the primary intervention. He pointed out that the aim of the intervention is to help clients know the Lord Jesus Christ better, imbibe basic Christian ethics, adopt appropriate behaviours; morally, and socially. He said that the totality of the intervention facilitates change.(prayer, training, individual and group counselling sessions, daily Bible reading and reviews, especially the New Testament which focuses on the life, ministry, the miracles and training of the Lord Jesus Christ). He explained that the Bible reading and reviews enabled mind transformation and spiritual growth. Moreover, he claimed that rules and regulations of the agency also facilitate recovery.

Turning to vocational training programme, the training coordinator stated that the vocational training is aimed at skill acquisition, at preparing service users to be responsible for themselves by taking on jobs or setting up personal businesses. He said that acquiring a skill will assist service users not to be idle after training, a factor

which he claims promotes relapse. This training not only includes vocational training (hair dressing, catering, secretarial studies, carpentry, plumbing, and computing) but also training in higher institutions of learning like educational and theological institutions. Service users were sent for training in respective establishments while still living in W.R.C. This is complemented by weekly assessments from the trainers, to monitor the progress of service users and address whatever issues were arising from the training. The training coordinator said that the period of vocational training is the real testing ground for recovery, because this was when service users were released back into the society after five months of confinement. To tackle the problem of relapse, he said that service users were prepared, before the commencement of the programme, by receiving training in relapse prevention. This training was aimed at helping service users to manage 'high risk' situations at social gatherings, negative affective states like anger, depression, and cognitive distortions (like beliefs such as 'once an addict, always an addict'). He alleged that these training have helped to prevent relapse. He concluded that the vocational training programme did work as revealed in the quote below:

> 'And at the end of the day, ultimately and by the special grace of God they are re-integrated into the society, into their families and they become responsible men and women.' (Coordinator, W.R.C.)

Nevertheless the training coordinator acknowledged that there were three main challenges to recovery during the treatment period. The first was difficulty in coping with withdrawal symptoms during the first week of admission, since the means of withdrawal was natural withdrawal. Second was the difficulty in reforming from old habits like lying and stealing. To support this point, one of the care-staff suggested

that negative attitudes and behaviours which he called 'joint mentality' were a real challenge demonstrated because the treatment centre was the first place of contact when service users came off drugs. He said this included the use of improper language, being selfish, quarrelling and fighting. He explained:

> 'Em this is a kind of mentality, because it's a street mentality where you have em hooliganism, a kind of care free lifestyle' (Care-staff , W.R.C.)

The third challenge was from relapse, during the period of vocational training when the service users were release to go to their various vocational training centres.

In addition, the coordinator for the women and children suggested that the main challenge experienced by the females was quitting the treatment programme. This happened immediately they had withdrawn from the drugs and regained their health, and did not feel the need to continue with treatment:

> 'The peculiarity the women have that is different from the men is that, the women when they come in, we find out that after a few weeks, after they look good, they feel good, they feel they are okay and they want to leave before the end of the five months discipleship programme that is set out for them' (Coordinator, W.R.C.-3)

One of the female informants agreed with this assessment. She said:

> 'By that time I put on weight and I feel am too fine that I can go out and show to my friends. That's when I pass out and when I go I did not come back again' (Anna: 30 years, unsuccessful back in treatment))

Counselling intervention

The counselling therapies used were group counselling, individual counselling and career counselling. In interview, the counselling coordinator stated that the general aim of counselling was to uncover deep seated information about counselees, which might facilitate their rehabilitation. Group counselling, is set out to provide a forum where people with similar problems, would be given the opportunity to assist each other to resolve their problems. He saw this as a helpful programme because people were open to one other and opening up helped them to learn from the other person's experience and support one another. This was made easier because most of the counselees are known to themselves in the joints. The group was usually mixed and consisted of 25-40 persons admitted at the same time, and commenced about two weeks after admission. A typical session may take between two to four hours because people want to pour out their hearts. The coordinator said that sometimes there are emotional outbursts, and this was managed by being supportive such as encouraging the person or sharing a story. After the group counselling meetings, issues concerning individuals were picked up and later explored on a one-on-one basis during individual counselling sessions.

Moreover, he explained that the group counselling sessions facilitate recovery because people could relate to one another: they not only have similar problems but took comfort from themselves. For example, he said that those who had spent long years in dependency such as 35 years were often challenged by those in treatment for a few years like two years and wished they had been here earlier. Similarly, those who have been on drugs for a shorter period of time like two years would be grateful for seeking help early and not wish to be in that position. So seeing themselves as worse off or better, it helped them to plan ahead and reposition themselves. In addition to learning from this process, he claimed that this also served as a source of support to them. He also said that since the group was made up of different types of former drug users they were able to learn about different types of drug using experiences. In addition he suggested that the counsellor attributes such as empathy and the gift of exhortation which he possesses, helped to facilitate the effectiveness of counselling (The gift of exhortation was anchored on Romans 12:6-8).

On one- on- one counselling, he explained that there are three stages the counsellees move through: the first and second stages were introduction and exploratory, respectively, and the third stage was problem solving and goal setting. He also said that it is after the exploratory stage, that a counselling plan was designed for each individual. This plan is followed during the problem solving and goal setting stage.

The challenges faced are related to one-on-one counselling, because he had to counsel a large number of persons that is between 25-40 persons, during a five month

period which was sometimes overbearing for the counsellor. To resolve this problem, he suggested that plans are in place to train more counsellors. He also suggested that the one-on-one counselling gave him the opportunity to corroborate what was said during the group counselling sessions.

On the evidence of recovery he asserted that recovery is very visible and this visibility constitutes the greatest evidence. He claimed that before treatment, the common visible aspect of drug dependency was that they were unkempt because they did not pay attention to their health and looks, but were just lost in consuming drugs. This is revealed in the quote below:

> 'The first evidences of recovery you start seeing within a few weeks, is that they become clean, and their skin starts to glow. After five months, physically, they are totally different people. And when they get out of here and they start work, it is visible, it is visible. And then of course, is the change of their character which is the foundation of what we do here and the system that we use. There is a transformation in the person and the way they behave…..' (Counselling coordinator)

He defined recovery as 'recovery of basic traits of humanity.' He explained that during the course of counselling, he discovered that most of the crimes committed on the streets are carried out by drug-dependent persons due to the influence of drugs. Therefore, he asserted that recovery from drugs and associated lifestyle is a recovery of basic trait of humanity.

Other interventions

W.R.C. (2011) states that there are two supportive interventions, for those in the second phase of treatment, and ex-service users. The first is the collaborative family programme and the second, after-care. The collaborative family programme, is a monthly interactive resident-family/guardian session tagged ‘family forum’, and this takes place every first Sunday of the Month from 12:30 pm to 2:30 pm. The aim of the family forum, is to foster a collaborative effort between the agency and the family members of service users, to prepare the service users, for a more meaningful and productive life on completion of the treatment program. It also sets out, to correct any negative attitude on the part of the family members toward the service users. Through this they are prepared to become a positive support for the service users after completing the treatment program.

The second supportive intervention, the after-care is carried out through two strategies: the alumni meetings and individual follow up. The alumni meetings are held bi-annually. The aim of the alumni fellowship is to foster interaction among service users; through this means they can challenge themselves to making improvements. Regarding individual follow-up, the Coordinator After-care, actively maintains contacts with as many service users as can be reached, by phone calls and visits.

From the discussion in this section, the WRC model reflects not just a spiritual model but an integrative treatment model of care from dependent drug use that

incorporates the spiritual, emotional, social, financial, and educational aspects of recovery. It also reveals that drug dependency is much more than dependence on chemical substances; it reflects a persistent drug seeking lifestyle. Further, findings reveal that the recovery journey is not a short episode but a long one, which requires total care such spiritual, emotional, physical, financial and educational; and continued support all the way. The women and children's coordinator revealed that the responses of the women during treatment were different from the men. This finding points to the need for further research on the subject.

Definitions of recovery (proffered by staff of agency)

On the evidence of recovery, one of the coordinator's , suggested that total abstinence, good physical health, active participation in Christian activities, family re-union, high moral standards, well-being, good dressing, are some of the observed changes. On the meaning of recovery, another coordinator claimed that this means abstinence from drugs and remaining in good health. In addition, one of the care-staff, who was also a former service user, suggested that recovery means being abstinent from drugs, and ability to reason normally and live a normal life.